

DEATH EDUCATION IN NURSING AND MEDICAL CURRICULA:
AN INTEGRATIVE LITERATURE REVIEW

by

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ABSTRACT

Death is an inevitable experience for each individual. Although death is a natural human experience, the avoidance of death is an issue in the culture at large. This isolation of death and dying also is evident in the health professions of nursing and medicine. Despite the fact that death and dying has received considerably more scholarly attention over time, relatively little attention has been given to the topic of death education. This study explores the literature on death education within nursing and medicine from the 1970s onwards.

Using an integrative literature review, scholarly articles were reviewed to determine how death education is enacted or made real in the health care environment, particularly in the nursing and medical curricula. This study examines how educators have taught the topic of death and dying over time and how an analysis of these past experiences may inform current education on death related concepts within health professional fields. The lack of attention to death and dying in nursing and medical curricula affects the confidence and competence that health care professionals have in managing these situations. Although death is a common occurrence in the health care environment, there remains a gap in how educators are supported to teach these concepts to students.

The analysis of scholarly literature from the 1970s until the present reveals three themes. The avoidance of death in the culture at large, the importance of psychosocial aspects of care, and the lack of support for educators are three over-arching themes. The main recommendations for educators teaching death related topics appearing in the literature reviewed center on ensuring student contact with terminally ill and dying patients in the clinical setting as a way to learn about the dying process, use of simulation based learning, encouraging collaboration amongst the interdisciplinary team to meet patient and family needs, and the use of explicit

competencies related to end-of-life care to ensure consistency amongst all students. The findings from this review are relevant for student learning, educator preparation, and may also influence how educators in the health professions incorporate death and dying concepts into their curricula.

PREFACE

This thesis is original, unpublished, independent work by the author A. Powar.

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To Pitha ji

CHAPTER 1: Background and Research Question

1.1 Introduction

Death and dying are natural human experiences. The study of death, however, is isolative in the nursing profession (Schim, Briller, Thurston, & Meert, 2007). Nursing educational literature is one source focusing on the knowledge and competency needed for nurses to provide guidance to patients and families experiencing death. While death is a major occurrence in the practice of nursing, nursing curricula have limited attention to death and dying concepts. Such a lack of attention may prevent nurses from feeling competent in this domain. In addition, nurse educators may be hesitant to teach about this topic if they are not well informed about the best practices or have limited experience themselves with death. In this thesis, I will explore the literature on death education in nursing and medical disciplines and focus in particular on the perspectives of nurse educators.

For several decades, nursing and interdisciplinary scholars have discussed the barriers to the development of competency and confidence in death education. Barriers may include the silencing of death and dying in the culture at large, nurses' fears of dealing with a dead body, and a lack of preparation in nursing education (Bloch, 1976; Schim et al., 2007). Specifically, Bloch observed these obstacles in the 1970s, now almost forty years ago. Still, the literature persistently addresses that nurses experience insufficient preparation of death and dying during their basic education (Dickinson, 2007; Lev, 1986; Mermann, Gunn, & Dickinson, 1991). These selected references illustrate that both practicing nurses and nurse educators face continued difficulty to develop a sense of confidence around best practice in what could be framed as "death education" over the last forty years.

Nurses' personal fears, assumptions, and anxieties may impact their ability to care for patients and families experiencing death, but also may affect their ability to teach the topic and integrate it in the nursing curriculum. Several scholars have argued that improved educational preparation of nurses would increase their confidence and competence in managing these situations (Dickinson, 2007; Lister & Gochros, 1976; Wass, 2004). Wass (2004) highlights that there has been scarce attention on death and dying in all health care professionals' curricula. In nursing curricula, many include end-of-life issues but with limited time devoted to this topic due to limited space in programs and a lack of commitment from educators to teach these topics (Dickinson, 2007; Malory, 2003). The emotions associated with death and the dying process may make discussions of these topics difficult for all stakeholders involved. Caring for patients and families at the end-of-life is a complex task and entails a large responsibility for nurses and all health care professionals.

1.2 Background

The difficulties of teaching about death and dying in nursing curricula stems primarily from the silencing of death in the Western culture at large, an observation scholars have persistently made since the 1970s (Armstrong, 1987; Knight & Elfenbien; Lister & Gochros, 1976; Wass, 2004). According to Kubler-Ross (1975), a leading scholar on this topic since that time, death is inevitable and is as much a part of the human experience as birth is. Still, a death denying society coupled with unknowns about the dying process make death an isolative event. Fears and avoidance behaviours surrounding death grow from a lack of experience and knowledge along with a youth worshipping society where death is ignored (Lev, 1986; Lister & Gochros, 1976). Lister and Gochros (1976) suggested that death concepts may be best learned through experience and therefore people reaching maturity without much exposure to death may

have little or no experience with the dying process. Death creates discomfort and raises emotions that people may not be prepared to manage.

Kubler-Ross (1975) suggested that birth and death are undifferentiated parts of life. While a youth-revering society may be enriched with knowledge about the birth process and early stages of human life, death and dying remain unknowns (Lister & Gochros, 1976). These ideas may be paralleled in nursing curricula where great emphasis is placed on holistic nursing of a person from birth to death as offered in the seminal work of Florence Nightingale in the late 19th century (King & Gates, 2007). However, while holistic care throughout the lifespan is a key component to nursing practice, there appears to be greater emphasis on learning about birth and developmental stages of one's life and less importance is placed on the dying process in nursing curricula and textbooks. Still, death is a normal experience in the journey of life that cannot be ignored, as it is the final step of the growth process (Kubler-Ross, 1975).

Over the last forty years, nursing education has generated many changes to curricula and to which topics are taught in nursing programs. In the early 1960s and 1970s, little attention was given to end-of-life issues and death education (Dickinson, 2007). Jeanne Quint Benoliel (as cited in Ferrell, 2012) was one of the first nursing scholars who broke the silence surrounding death and dying during this time. Quint's influential work established a new way of thinking about nurse-patient relationships, the loss and grief endured by families, and the need for specialty education for nurses who were caring for patients at the end of life (Ferrell, 2012). Based on the framework offered by Quint, new studies were taken on in the 1980s that explored insights on how to support student learning about death related topics (Degner & Gow, 1988a). These studies will be discussed as a part of the review in this study. In addition, in the early 1980s, at some institutions revisions were made to nursing baccalaureate programs in which

death and dying were integrated into the courses (Dickinson, 2007). In order to include an exploration of these important curriculum revisions and shifting views on death education, published articles and selected nursing textbooks from the 1970s onwards will be examined in this study.

My quest into researching this topic began after my supervisor introduced me to the topic. After reading through some articles about death and dying education in nursing curricula, I could relate to the lack of preparation and comfort surrounding death and dying in my own nursing education. I believe there is a great need for nursing curricula to focus on the topics of death and dying in baccalaureate education so that nurses are better prepared to deal with death upon entry into the workforce. From my current experience as a practicing nurse at the bedside, I am aware of the hesitation nurses have when working with patients at the end-of-life. I am concerned by the lack of comfort and the stress caused when nurses are faced with difficult death and dying situations, as death is a common occurrence in the practice of nursing and in the healthcare environment.

1.3 Problem statement

Nursing curricula lack a focus on death and dying education. This problem has been reported not only in nursing but also in the medical literature over the last half century; however, these trends still exist in the current literature. The barriers to adequately address death education in nursing and other professional programs are due to the silencing of death and dying in the culture at large, nurses' personal fears of dealing with a dead body, and a lack of preparation during training (Bloch, 1976; Schim et al., 2007). Other factors include limited time available in nursing curricula to teach the topics of death and a lack of faculty who feel prepared to teach

these classes. The research suggests that there are knowledge gaps and inadequate preparation of nursing and medical students to deal with the complexities of death (Dickinson, 2007).

It is evident that there are many different methods to teach topics on death and dying within varied curricula. For example, the recent work of Kurz and Hayes (2006) highlights a curricula consisting of nine modules taught in didactic form which reveal critical aspects of caring for the dying including pain management, symptom management, bereavement, ethical issues, cultural considerations, preparation at the time of death, and quality of care at the end-of-life. While going back to the 1970s, Stefan and College (1978) reviewed a course that was divided into three parts including death customs of cultures, psychological processes involved with death, and finally the practical applications of death education. Yet, systematic discussion of the literature on death education had not received much attention. Very few integrative reviews of the literature on this topic exist. Mallory (2003) suggests that there is a lack of confidence among educators, as one of the main reasons why death education is limited. The study however, describes the impact of death education on student learning instead of focusing on how to support the role of the educator. Furthermore, Wass (2010) alludes to the current state of death education and how a death-denying society leads to continued avoidance of death related discussion, yet, Wass (2010) too similarly focuses on the experience of students. In this study, a literature review is conducted focusing on the way death education is enacted from the viewpoint of educators and curriculum development. The review addresses in particular how death education is enacted.

In my thesis, I explore how education on death and dying has been constructed over time and how recommendations have changed as to the most ideal ways to teach these topics. Using an integrative literature review, I examined systematically how this topic has been approached

and how scholars articulated the way nurse educators and students should address the topics of end-of-life and death. Based on this review, I have made recommendations with regards to best practices in teaching students in nursing programs.

1.4 Research question and sub-questions

How is thanatology or “death studies” enacted and made “real” in nursing programs according to published scholarly literature in nursing and medicine and according to selected nursing textbooks from these decades?

- How do the cultural norms of death and dying influence how nurses and educators acknowledge the death experience?
- How does the normative discourse on death, position nurse educators to teach this topic to students so that they are more comfortable in dealing with death?
- What strategies are suggested in the literature to educate nurses on the way they might best provide care for those experiencing death and dying?

1.5 Conceptual framework

Using the lens of performance theory, this paper examines how nurses and educators practice and enact situations of death, loss, and grief (Hadders, 2009). More specifically, the literature is analyzed to determine how end-of-life scenarios are made “real” or enacted in nursing and medical disciplines.

Analysis of the literature provides insights on how existing norms about the way death education should be taught in nursing curricula enables or constraints particular ways of teaching death and dying. The literature is evaluated for methods and content included in curricula or courses on death. The notion of text analysis is used to examine what is written about death

education and more importantly how this information is represented in health disciplines (Wall, 2006).

1.6 Methods

This study uses an integrative literature review approach. According to Whittemore and Knafl (2005), integrative reviews encompass both experimental and non-experimental research that provides a thorough review of a phenomenon. An integrative review on the literature about death and dying in nursing education over the last forty years may offer new perspectives on this topic (Torraco, 2005). This integrative review uses the same approach outlined by Whittemore and Knafl (2005), which includes problem identification, literature search, data evaluation, data analysis and finally the presentation of findings and conclusions. Torraco (2005) suggests that review of the literature over a longer period of time offers insights as to how discourses, in this case those surrounding death education, have changed and have been developed over the years.

The concepts highlighted in this study include cultural norms about death, and the way these norms are incorporated in current instructional discourses in nursing education. How these instructional discourses are implemented into curricula or course work is an additional area of interest for this study. One assumption made in this exploration, is that what constitutes best practice itself shifts and changes overtime. As such, effective practice and hence effective education is perceived as socially constructed and negotiated based on the practice context (Armstrong, 1987; Hadders, 2009). Dead body and deceased are two terms that are used interchangeably in the literature explored. These terms will both be used in this study.

1.6.1 Inclusion and exclusion criteria

The inclusion criteria for selection of references into my study were:

- health care literature from the last forty years (1975 – 2014)

- articles selected from published journal articles
- foundational nursing textbooks
- experimental and non-experimental research
- literature written only in English

The exclusion criteria:

- studies outside of health care disciplines
- gray literature

1.6.2 Selection criteria

Whittemore and Knafl's (2005) approach to integrative literature was used for this study. Because integrative literature reviews encompass various different research methodologies including experimental and non-experimental studies, there is concern for results lacking rigour, accuracy, and potential bias (Beck, 1999). The inclusion criteria were further refined when selecting appropriate research and scholarly articles for this study as follows:

- literature only from the last forty years was included (1975 – 2014)
- literature written in English only
- studies with diverse methodologies including experimental and non-experimental research were included to obtain broader perspectives
- literature searches were conducted using the following databases: CINAHL, PUBMED, PSYCINFO, MEDLINE, ERIC, and Google Scholar
- publications on death education in nursing, medicine and psychology were considered for this study

- studies and scholarly publications highlighting nursing education around death and dying were the primary focus of this study, yet the medical discipline also had several relevant articles, particularly in the early period of the study. These are included in this study as well.

1.6.3 Data collection

Existing databases of scholarly literature were used and explored systematically using the search terms “death, grief, loss, death education, and thanatology”. The literature search incorporated databases that reflect the literature in selected health disciplines including nursing, psychology, and medicine. These selected databases include CINAHL, PUBMED, PSYCINFO, MEDLINE, ERIC, and Google Scholar.

The inclusion criteria included literature from the last forty years (1975 - 2014) when the scholarly nursing literature expanded and curricula changed in tandem with the wider implementation of nursing baccalaureate programs (Dickinson, 2007). In the 1970s, baccalaureate nursing programs were introduced with many curriculum revisions (Dickinson, 2007). Therefore, in addition to exploring published journal articles, in this study I looked at selected foundational nursing textbooks from the 1970s onward. I have selected one or two nursing fundamentals textbooks commonly used in Canadian nursing curricula for each decade. “Common” is indicated by the fact that of the identified textbook, multiple editions have been used over time, suggesting that it was a book in demand. From the textbooks, I explored in particular the educational material on death and dying included in the book.

Integrative reviews should be inclusive of both previous research and current research to develop a comprehensive understanding of the research topic (Torraco, 2005). In summary, the inclusion criteria encompassed literature published in journals, both

experimental and non-experimental research, most of which is available in electronic format. Literature related to death education was evaluated from nursing and medicine.

1.6.4 Organization of study

This study explores literature and textbooks by decade. The next chapter examines published journal articles from 1970-1979 as well as nursing textbooks used during that time. The subsequent chapters will review literature from 1980-1989, 1990-1999, and finally 2000- present. Discussions of key findings and themes will be presented at the end of each chapter followed by a conclusions and recommendations section as the final chapter of the study.

The beginning of each chapter is introduced with a table indicating the articles explored in the identified time frame. Since this study explores changes of death education over time, the articles are organized chronologically and also grouped by discipline or themes to highlight the different perspectives of authors on a common topic. Contextual literature is also included for each decade as relevant. Each chapter will conclude with key findings and themes presented in that time period. The final chapter of this study will include conclusions and recommendations from the scholarly literature explored.

CHAPTER 2: Emergence of Death Education

2.1 Introduction

The 1970s were a time during which the topics of death and dying were receiving more attention in society. Significantly, the influential work of Kubler-Ross emerged during this time. Some researchers suggest this increasing interest on the topic was in part due to the contextual influence of a large number of assassinations in the 1960s and the war in Indochina (Lister & Gochros, 1976). In addition to the higher incidence of death in the public domain, new technologies to prolong life were being introduced in healthcare facilities (Barton, Flexner, Van Eys & Scott, 1972; Lister & Gochros, 1976). People were starting to live longer through new advancements in pharmaceutical drugs and technologies within the health care system. As a result, a change was emerging in a previously death-denying society.

This change also appeared to have prompted the introduction of death education in the curricula of health care providers who were in contact with patients and families experiencing death. Death and dying were receiving attention in professional education. The following articles have been selected for review during this time frame. It is noteworthy to comment that the most relevant articles related to death and dying education first emerged in medical and psychiatry disciplines. Very few articles related to death education were published in nursing journals at this time. In fact, only one nursing article was found using the search terms.

Table 2.1 Articles and textbooks selected for review from the 1970s

Medicine:

Barton, D. (1972). The need for including instruction on death and dying in the medical curriculum. *Journal of Medical Education*, 47(3), 169 – 175. doi: 10.1097/00001888-197203000-00002

Barton, D., Flexner, J. M, Eys, V. J., & Scott, C. E. (1972). Death and dying: A course for medical students. *Journal of Medical Education*, 47(12), 945- 951.

doi: 10.1097/00001888-197212000-00004

Liston, E. H. (1973). Education on death and dying: A survey American medical schools. *Journal of Medical Education*, 48(6), 577 – 578. doi: 10.1097/00001888-197306000-00007

Bloch, S. (1976). Instruction on death and dying for the medical student. *Medical Education*, 10(4), 269 – 273. Retrieved from <http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/j.1365-2923.1976.tb00457.x/pdf>

Psychiatry:

Snyder, M., Gertler, R., & Ferneau, E. (1973). Changes in nursing students' attitudes toward death and dying: A measurement of curriculum integration effectiveness. *International Journal of Social Psychiatry*, 19(3), 294 – 298. doi: 10.1177/002076407301900322

Stefan, E. S. & College, F. (1978). Perspectives on death: An experiential course on death education. *Teaching of Psychology*, 5(3), 142- 144. doi: 10.1207/s15328023top0503_8

Nursing:

Ufema, J. (1977). Do you have what it takes to be a nurse-thanatologist? *Journal of Nursing*, 7(5), 96 – 99. Retrieved from <http://web.b.ebscohost.com.ezproxy.library.ubc.ca/ehost/detail?sid=9a0d64e3-599b-4373-941a-24274bcb6305%40sessionmgr115&vid=1&hid=125&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl>

Textbook:

Harmer, B., & Henderson, V. (5th Ed). (1967). *Principles and practice of nursing*. New York: NY: Macmillan.

Henderson, V., & Nite, G. (6th Ed). (1978). *Principles and practice of nursing*. New York, NY: Macmillan.

2.2 Analysis of literature

The literature analyzed in this time frame is organized chronologically in order to identify changes in death education over time. Specifically, the following chapter will explore scholarly literature from 1970-1979 and will be further organized by discipline as the topics of death and dying were first introduced mainly in medical and

psychiatric disciplines. The final portion of the chapter will include some literature from nursing disciplines including two textbooks used during this time. The main themes apparent during the 1970s were the use of patients as primary teachers for students and the inclusion of psychosocial aspects of care for patients and families facing death (Barton, 1972; Bloch, 1976; Stefan & College, 1978). These themes were present across both medical and nursing curricula.

2.3 Medicine

The most prevalent death education literature was presented in medical journals during the 1970s. The articles selected identified the need for instruction on death and dying in medical curricula and also reiterated what should be included in course work. Barton (1972) suggested that while physicians are in close proximity to death, there is a great deal of avoidance toward the topic of death primarily due to personal fears and expectations that all patients will get well. Death may also represent failure as a health care practitioner as physicians are trained with high expectations that patients will get well. Medical students enter their studies with varied levels of knowledge and experience with death. Therefore, these topics may be more difficult for some than others. Barton (1972) revealed that while instruction on death and dying is included in medical curricula, it is generally in an indirect form, such as how to obtain autopsy permits or manage critical situations on the ward (Barton, 1972). He highlighted that lectures and presentations may not be the most effective ways to teach topics that evoke feelings and emotions. These concepts required more discussion and direct contact between instructors and students. Reflecting on the findings from his study, Barton (1972) recommended small group discussions as the most effective method to allow medical students to amalgamate their feelings and attitudes towards death and dying by discussing the common concerns and conceptualizing death and dying experiences. One method used to teach medical students about the last stages of

a patient's life was through a "psychological autopsy" in which the medical, social, and psychiatric aspects of the dying experience were brought together (Barton, 1972). Such an autopsy provided in depth insights to medical students about disease processes as well as changes that occur to the body at the end-of-life. This author also suggested that due to the difficult nature of the topic of death, reiteration and consistent teaching at all levels of medical school is needed. Death education should first be introduced in the early stages of medical school when students encounter a cadaver and then again as students enter clinical rotations (Barton, 1972). This article examined how medical schools recognized the psychosocial dimension to death and dying and introduced new methods of teaching that encouraged students to discuss their concerns through peer activities.

Similarly, the work of Barton, Flexner, Van Eys and Scott (1972) stressed the importance of death and dying education in medical curricula. Specifically, the authors described a death and dying course that was introduced in one medical school that spanned over one semester. The course objectives included investigating personal reflections and fears associated with death, developing an awareness of the psychosocial processes and sociocultural issues surrounding death to achieve a humanistic approach to caring, and examining ethical issues (Barton et al., 1972). Discussions on the topic of death encouraged students to explore their personal feelings about death and dying. The classroom was set up with only a few students to maximize discussion and interaction amongst colleagues. The course was led by a psychiatrist, hematologist, professor of philosophy, and a pediatric hematologist. Weekly presentations varied from guest speakers including patients managing a terminal illness, literature from selected dialogues and readings, and group discussions with health care providers including nurses, pastoral counselors and rabbis' (Barton et al., 1972). Students engaged in role playing activities

in which one student played the role of a patient while the other was given a health care professional role to enact an end-of-life scenario (Barton et al., 1972). Role-play enabled students to learn about the perspectives of patient, family, and health care professional.

The findings from the study revealed that students developed a uniformity of their attitudes towards death and dying through group interaction and common positions about their fears about death (Barton et al., 1972). The diversity in topics and guest speakers provided students with opportunities to learn about the roles of each member of the health care team and the importance of collaboration amongst team members was highlighted throughout group discussions and reflections (Barton et al., 1972). Learning from other members of the health care team may help professionals understand the roles and responsibilities of other stakeholders involved in patient care and also provide a broader conceptualization on the topic of death.

To reflect on the incidence of death education in medical schools during this time, Liston (1973) developed a survey with the focus question “does your medical school curriculum presently contain a formal or structured program of instruction for medical students on the psychological care and understanding of patients with fatal illnesses?” The survey was sent to one hundred four medical schools in the United States. Of the eighty three schools that responded, forty two stated that they had no formal education on death and dying in their curriculum (Liston, 1973). The remaining thirty four schools that responded that formal education was included in their curriculum were further examined for the duration, format, class composition, instructional aids and faculty for these courses. Approximately ninety percent of the death education courses had been in existence for less than five years and were offered primarily in the freshman and sophomore level (Liston, 1973). A variety of course formats were highlighted throughout the article. These formats included lectures and seminars as the most

frequently used method with two to forty five hours of instruction on the topic of death (Liston, 1973). Liston (1973) revealed that one common teaching and learning method favoured by the respondent schools was to have students conduct patient interviews with those experiencing fatal illnesses. Also, videotape recordings were reported as useful instructional aids. Patients were seen as the main source of instruction for students as they gained understanding about a patient's experience with dying from personal dialogue (Liston, 1973). Student-patient contact was imperative for learning about the death and dying experience. Film footage and role-playing were also employed often but assigned readings and audiotapes were viewed as less effective in teaching the topic of death (Liston, 1973). Faculty teaching these courses comprised of staff from the medical and psychiatry departments (Liston, 1973).

Similar to Liston, the importance of student-patient contact was also expressed by Bloch (1976) who emphasized the importance of each student caring for one terminally ill patient until their death. In this study, one hundred and four American medical schools were sent a questionnaire about death and dying education. Eighty-three schools responded out of which forty two replied that they did not offer any formal educational programs on death and dying (Bloch, 1976).

The nine objectives identified by Bloch (1976) as key components to death and dying education included: the removal of barriers; an appreciation by the student of his own death; the contribution to the students psychological growth; an appreciation of what it is like to be dying; an appreciation of the family's needs; an appreciation of the roles of other personnel; the cultural aspects of death and dying; and the ethics of death and dying and management of the physical distress of the dying. It was thought that knowledge on these topics might provide students with the necessary tools to care for patients and families who are facing death. Similar to the views of

Liston (1973), Bloch (1976) highlighted that the best teachers on death might be terminally ill patients who shared their fears and experiences of having a life-threatening illness with students. Patient as teacher was seen as a unique method for students to learn about the patient's story, their feelings and fears. Students then shared their experiences within their clinical groups and learned from one another. In this way, students connected with the patient but would have opportunity to address patient and family concerns and also grapple with their own fears surrounding death.

2.4 Psychiatry

The work of Snyder, Gertler and Ferneau (1973) was discussed in a psychiatric scholarly journal which focused on the nursing curriculum at the Boston City Hospital School of Nursing (CHSN). This nursing curriculum was comprised of both clinical and classroom experience. During the first year of the nursing program, students were required to take an introductory course titled "communications" which was a lecture-based didactic and group discussion format to aid students in managing their own beliefs and fears surrounding death (Snyder et al., 1973). The first year course also included a six month experience which enabled students to care for a dying patient along with more practical experience in their second and third years (Snyder et al., 1973). Similar to the medical program, the nursing curriculum in this study used patients as the primary teachers for students. Students were paired with a patient for six months, which gave them time to build a trusting relationship, understand the patient's story and reflect on their dying process.

A "social concern subscale" was administered to students as a part of this study to both freshman and senior nursing students (Snyder et al., 1973). The questionnaire was made up of questions related to student anxiety and thinking about their own death or death of a loved

one. Results showed statistically significant changes in the attitudes of senior students who had received three years of death education courses and clinical exposure compared to the freshman students who received a limited amount of education around the topics of death (Snyder et al., 1973). The conclusions drawn from this study indicated that the primary goal of death and dying education was to expose students to their own anxieties and fears about caring for a dying person in a group environment where shared learning was fostered (Snyder et al., 1973). Students who were comfortable talking about death were believed to be more effective health care professionals in aiding their patients and teaching about death related changes.

A “death course” constructed by Stefan and College (1978) was titled “studies in personality: death education” and spanned a total of ten weeks. The course involved students applying factual material to their personal feelings and experiences (Stefan & College, 1978). The course was divided into three main units including death customs, psychological processes in facing one’s own death or death of a loved one, and practical applications of death education (Stefan & College, 1978). The first unit on death customs used didactic approaches for learning about the norms and beliefs of various cultural groups, which was supplemented with discussions, visual aids and guest speakers from community residents of various cultural backgrounds (Stefan & College, 1978). In the next unit, students learned how cultural influences play a significant role in how patients and families care for their loved ones at the end-of-life which often involves special rituals or customs with the dead body. In the psychological processes unit, the focus was on topics such as denial, grief, fear, and acceptance, students wrote their own obituary and a panel discussion with health care professionals was held (Stefan & College, 1978). In the third unit on practical application of death education, topics such as suicide, living wills, cremation, funerals and euthanasia were explored and augmented by film

and group discussions with lawyers and insurance agents (Stefan & College, 1978). Topics related to practical application assisted students in learning about what happens during the time of death, care of the dead body and also how to prepare the body for viewing and the morgue.

Simulation was a preferred method of teaching used in this program to make situations of death real in the learning environment (Stefan & College, 1978). The simulation engaged students to act out scenarios of the patient, health care provider, or family and engage in discussion and dialogue amongst themselves in order to gain experience in how to manage these difficult situations in a safe setting (Stefan & College, 1978). It was hypothesized that simulating scenarios could decrease the anxiety students might have in speaking with patients and families if they first had some experience practicing on a mannequin in a safe learning environment. Simulation helped students with critical thinking and prepared nurses to deal with real death and dying situations if practiced on a simulator doll as it could mimic the changes that occur in a dying patient (Stefan & College, 1978). These authors stated that simulation provided opportunities for learning as students discussed and reviewed their performance in these scenarios with their instructor and colleagues to find areas for improvement.

In a follow up survey six months later, student feedback suggested that the course helped students acknowledge their own fears surrounding death and students felt more comfortable having conversations about death as it was practiced in their simulation scenarios (Stefan & College, 1978). Simulation helped improve self confidence and decreased fears of managing the complexities involved with death and dying care when these situations were practiced on a mannequin doll.

2.5 Nursing

Nursing literature on death and dying was scarce during the 1970s. One exception was Ufema (1977) who highlighted the qualities and characteristics that are reflective of a nurse-thanatologist. A nurse thanatologist is an individual who is experienced with the concepts of death and dying (Ufema, 1977). Characteristics of a nurse-thanatologist include having an idea of one's own philosophy on death, being an effective patient advocate, offering self-control to the dying patient, and giving emotional support to patients and their loved ones (Ufema, 1977). Learning about death was also thought of as on-going through a nurses professional career. Death education could be enhanced through attending in-services, seminars, and workshops but also learning through patient interactions by being involved in patient care during the end-of-life (Ufema, 1977). Ufema (1977) alluded to the scope of responsibilities that nurses have in caring for patients at the end-of-life including advocating for their needs and rights to be told their diagnosis and also being gentle and honest in patient interactions. Understanding what the patient wants and giving control to the dying patient was fundamental to the role of a nurse-thanatologist (Ufema, 1977). Patient interaction and contact with families is a prevalent theme in this article as practical experience appears to be seen as the best method for students to engage with the topics of death and dying.

Nursing textbooks during this time period were explored to gain understanding of the topics of death and dying that were included within nursing educational resources. Upon exploration of Harmer and Henderson's (1967) nursing textbook titled *Textbook of the Principles and Practice of Nursing*, it is evident that the topic of death and dying is broadly described in twelve pages. The topics highlighted in the chapter include signs of approaching death, nursing care of the dying, care of the body after death, and public health regulations on disposition of the

body after death (Harmer & Henderson, 1967). The topics are touched on briefly but no in-depth analysis is provided on how to communicate with families or which changes to expect when a patient is nearing death. Emphasis on psychosocial aspects was not included while more attention was paid to physical appearance of the dead body.

Preparation of the body after death is described as the process of making the patient look as natural as possible by ensuring cleanliness, closing of the eyes and mouth, and ensuring clean linens and environment (Harmer & Henderson, 1967). Providing an itemized list of all patient belongings is important for families to receive (Harmer & Henderson, 1967). This textbook guides the student with the nursing actions and steps to take with bathing the body and preparing the patient for transport to the morgue. However, psychological aspects of death and dying care such as family centered care and how to provide psychosocial support to patients and families were not yet included in the textbook's 1967 edition.

In a later edition of *Principles and Practice of Nursing*, the death and dying chapter was expanded to include nine core concepts. The chapter now encompassed a total of seventy-one pages. Concepts included beliefs and customs surrounding death, signs of an approaching death, setting, principles and goals, roles of caregivers, symptomatic management, pronouncing death, care of the body after death and bereavement (Henderson & Nite, 1978). The topics were discussed in far more detail than the previous textbook and more attention was given to family care, which was one element not addressed in the previous textbook.

The chapter described in detail the lack of formal education on death and dying in nursing and medical school curricula and the lack of prepared faculty to teach these topics (Henderson & Nite, 1978). The postmortem care is discussed in detail as being the most fearful part of the death care for nurses (Henderson & Nite, 1978). Symptom management and how to

best provide holistic care for a dying patient is described through the roles of nurses, physicians, social workers and other members of the health care team (Henderson & Nite, 1978). Providing comfort care is key to patients who may be experiencing various symptoms such as pain, nausea, and constipation. The importance of cleaning the body, practicing using cultural competence, closing mouth and eyes, removing of personal belongings, changing soiled dressings and linens, and marking the body appropriately are explored (Henderson & Nite, 1978). These final steps in caring for a deceased body can be stressful for nurses and be emotionally challenging. Therefore, the systematic exploration of how to care for the body can be helpful for students when learning post-mortem care and for experienced nurses needing a refresher on how to care for the deceased.

2.6 Discussion

The major themes presented from 1970s include the incorporation of psychosocial aspects of death and dying education and the view that patients seem the primary teachers for death education (Barton, 1972; Barton et al., 1972; Bloch, 1976; Liston, 1973; Snyder et al., 1973; Stefan & College, 1978; Ufema, 1977). These topics were most prominently discussed in medical and psychiatric journals, however; these ideas were echoed in the nursing published literature during this decade.

Death is seen as a difficult topic of discussion. The feelings and emotions associated with death and dying underscored the importance of psychosocial care of all stakeholders involved. Barton (1972) and Bloch (1976) highlighted how concepts of end-of-life and death may be best learned through group interactions and discussions reflecting on feelings, emotions and fears surrounding death. In addition to physical care, it was imperative to consider the psychological care of patients and families who are experiencing loss, grief and denial (Stefan & College,

1978). Appreciating the patient and family specific needs and learning about any rituals or cultural aspects to end-of-life care can help manage the distress involved with dying.

Psychological care was a new focus of care, as was the idea of patient and family centered care during this decade. In the medical curricula, the students psychological processes of death and dying were explored through student encounters of a dead body and viewing of an autopsy where instructors encouraged students to talk about their fears and concerns with their peers (Barton, 1972; Barton et al., 1972). On the other hand, in nursing curricula, the focus of psychological care was emphasized through communication courses where students learned how to talk about death topics and shared their personal experiences with death (Synder et al., 1973).

In addition, the topics of denial, grief, fear and acceptance were stressed as a part of learning of the psychological processes of death (Stefan & College, 1978). This recurrent theme of psychosocial care of patients and their families revealed the new importance of this topic in relation to death and dying. Perhaps, the inclusion of this topic in scholarly literature was aimed at filling a gap in practice. Armstrong (1987) identified that psychological processes of anticipatory grief and loss were important discourses to discuss with patients and their loved ones. Although psychological aspects of care were beginning to receive attention in scholarly literature, there was not yet mention of psychosocial aspects of care in the two nursing textbooks analyzed in this decade. Still, the focus on death and dying expanded in the successive textbook editions that appeared during this decade. The inclusion of psychological aspects of care will be further investigated in the following chapters.

A major insight brought forward during this decade is the impact that patient interactions had on student learning about death and dying. Only a dying patient could provide insight on what it feels like to be dying and how this impacts their life and loved ones most authors argued.

In the medical journals, patients served as guest speakers in classrooms speaking about their terminal illnesses and also played the role of teachers as students were paired with them for their clinical rotations so that they could learn from their personal experiences of having a life threatening illness (Barton et al., 1972; Bloch, 1976; Liston, 1973). Similarly, in the nursing curriculum at the Boston City Hospital, students were given opportunity to care for a dying patient in a six-month clinical rotation (Snyder et al., 1973). During this decade, direct patient contact was expressed as the ideal method for students to learn about the dying process and to understand what it means to communicate and care for someone who is dying. This would help students create rapport with patients and their families and build trusting relationships with the very people who heavily relied on their care. This notion of talking about death and dying was seen as an essential part of death education that helped students bring the topic to the forefront and no longer avoid the topic of death.

CHAPTER 3: Learning About the Dying Process

3.1 Introduction

During the 1980s, there was emphasis in the literature on a major shift brought about by new technology that was introduced into hospitals. People were starting to live longer and often died in hospital while receiving aggressive treatments (Degner & Gow, 1988a). End-of-life care was being provided in the hospital more than the home. Caring for the dying was no longer limited to care on the battle fields as it had been in the past, where it was one of the prime responsibilities of professional nurses. Degner and Gow (1988a) argued that shifts in caring for dying people in hospitals coupled with new pharmaceuticals introduced new contexts of care and hence new learning opportunities for nurses.

New hospital insurance and medicare programs lead to an enormous increase in hospital care and hence growth in health care occupations (Armstrong, Choiniere, & Day, 1993). The health care environment endured many changes in the context of health education as well, including the movement of nursing schools from the hospital into community colleges and the continued transition of diploma programs to baccalaureate degrees during this time. As a result, the views on death education also changed.

The third chapter is also organized by discipline and chronologically. The articles listed in the table below were selected for this study during this decade. The themes embedded in the literature will be identified at the end of the chapter. The relevant scholarly literature from this decade arose from the medical and nursing disciplines.

Table 3.1 Articles and textbooks selected for review from the 1980s

<p>Medicine:</p> <p>Perez, E. L., Gosselin, J. Y., Gagnon, A. (1980). Education on death and dying: A survey of Canadian medical schools. <i>Journal of Medical Education</i>, 55(9), 788 – 789. doi: 10.1097/00001888-198009000-00009</p> <p>Smith, M. D., McSweeney, M., & Katz, B. M. (1980). Characteristics of death education curricula in American medical schools. <i>Journal of Medical Education</i>, 55(10), 844 – 850. doi: 10.1097/00001888-198010000-00005</p> <p>Field, D. (1984). Formal instruction in United Kingdom medical schools about death and dying. <i>Journal of Medical Education</i>, 18(6), 429 – 434. doi: 10.1111/j.1365-2923.1984.tb01298.x</p>
<p>Nursing:</p> <p>Fleming, S., & Brown, I. (1983). The impact of a death education program for nurses in a long-term care hospital. <i>The Gerontologist</i>, 23(2), 429 – 434. doi: 10.1093/geront/23.2.192</p> <p>Lev, E. L. (1986). Effects of a course in hospice nursing: Attitudes and behaviours of baccalaureate school of nursing undergraduates and graduates. <i>Psychological Reports</i>, 59(2), 847 – 858. doi: 10.2466/pr0.1986.59.2.847</p> <p>Degner, L. F. & Gow, C. M. (1988a). Preparing nurses for care of the dying. <i>Cancer Nursing</i>, 11(3), 160 – 169. doi: 10.1097/00002820-198806000-00006</p> <p>Degner, L. F. & Gow, C. M. (1988b). Evaluations of death education in nursing. <i>Cancer Nursing</i>, 11(3), 151- 159. doi: 10.1097/00002820-198806000-00005</p> <p>Textbook:</p> <p>Roach, M. S. (1st Ed.) (1987). <i>The human act of caring: A blueprint for the health professions</i>. Ottawa: Ontario: Canadian Hospital Association.</p>

3.2 Analysis of literature

Similar to the previous decade, it is important to note that the much of published literature surrounding death and dying still arose from medical disciplines but now more nursing

journals were including literature on death and dying. This may be due to increased awareness of end-of-life care and a medical culture shifting from a main focus on curing to one that incorporated caring. In addition, more emphasis was placed on cancer care. Cancer was a topic of discussion for all health care disciplines. Significantly, cancer patients were alluded to as excellent teachers for students and their experiences were seen as prime examples of the complexities of symptoms and problems patients might encounter as they would be nearing death.

The scholarly literature analyzed in this chapter explored journal articles from 1980 – 1989 from both medical and nursing disciplines. There is a shift in the number of scholarly nursing journals including literature on death and dying compared to the previous decade with more literature available on these topics. One nursing textbook was selected for review for this decade. The major themes of death and dying education from the 1980s included a continued emphasis on the importance of psychosocial care. New approaches appearing in the literature in this decade were more systematic studies of nursing student's attitudes about death and dying using theoretical models and examinations of the way newly introduced death education courses impacted nurses' practice. Both were key influences in the expansion of death education in nursing.

3.3 Medicine

In an article in the *Journal of Medical Education*, the authors Perez, Gosselin and Gagnon (1980) emphasized the poor state of death and dying education in Canadian medical schools. In particular, the lack of emphasis placed on psychosocial care when educating students on terminally ill patients. They found that death and dying courses were rarely reported as being offered as a full course but instead were integrated into human behaviour courses or offered as

electives (Perez et al., 1980). Instructors teaching these courses were from a variety of professional backgrounds. Such as psychiatrists, physicians, nurses, sociologists, internists and theologians (Perez et al., 1980). A multidisciplinary approach was preferred so that instructors could share their professional expertise with students and provide them with different perspectives of death and dying care (Perez et al., 1980).

The lack of importance placed on death and dying discourses was suggested as a result of the notion that a death of a patient may represent failure as a practitioner (Perez et al., 1980). Medical disciplines focused on teaching students about saving lives and helping people live. Less emphasis was placed within medical curricula on comfort care and end-of-life care (Perez et al., 1980). Avoidance behaviours of caring for the psychosocial needs of patients and families was due to a lack of confidence in acknowledging death and the feelings associated with death (Perez et al., 1980). This problem stemmed from lack of practical experience in relation to end-of-life situations and limited exposure to talking with patients who are dying. The ideas of Perez et al. (1980) reiterated many of the same observations discussed in the US medical literature explored in the previous decade.

Other medical schools appeared to be having similar problems with a lack of preparation for medical students to manage end-of-life situations during this time period. A cross-sectional survey was conducted amongst medical schools in the United States, which emphasized the limited inclusion of death education in medical school curricula (Smith, Sweeney & Katz, 1980). Medical students reported having death related anxiety due to a lack of preparation and a medical model that focused on curative care rather than palliative care (Smith et al., 1980).

Upon closer examination of death education curricula in medical schools, an increase was seen in the number of schools that included some form of death education compared to the

earlier survey that was conducted in the 1970s. The scope of the curricula, however, varied with some schools that offered simple discussions on the topic while others offered a course on issues associated with death and the process of dying (Smith et al., 1980).

The methods used to teach the death discourses in approximately eighty percent of schools included general textbook readings, videotapes, films and most frequently lectures but role simulations and case studies were only used in thirty percent of the schools (Smith et al., 1980). No mention was made in this study about clinical or practical experience for medical students to apply the knowledge gained from their courses. In the modifications section of the article, however, Smith et al. (1980) suggested changes in medical curricula to incorporate student-patient contact in practicums and during their clerkships.

In a study that evaluated the state of formal death and dying education in medical schools in the United Kingdom, questionnaire results from students and faculty revealed diversity in the course content, instructional methods used, and amount of time dedicated to the topics (Field, 1984). Lectures were reported as the most common methods used for instruction in the pre-clinical stages but small group discussions and case scenarios were favoured during the clinical years (Field, 1984). These changes in instructional methods could be a direct result of increased student knowledge and clinical experience over time.

Education on death and dying was fostered during both the pre-clinical years as well as the latter years in the clinical setting. Feedback from students underscored how didactic formal lessons in a classroom did not adequately prepare students to deal with patients and families at the time of death (Field, 1984). Didactic lessons taught students the theory they need to know to care for this population but did not give them any practice in using this knowledge. As a result, students preferred hands on practical experiences that would enable them to practice aspects of

providing psychosocial and emotional care for patients and families (Field, 1984). In addition, a textbook analysis showed that sixty percent of textbooks used in medical schools in the United Kingdom included a chapter or section on death education (Field, 1984). Textbooks were often used as supplemental resources to teaching and were seen as a great source of guidance for health care professionals when learning new skills.

3.4 Nursing

The article by Fleming and Brown (1983) is a striking example of how inadequate preparation and support for nursing staff for caring for dying patients lead to avoidance behaviours and poor patient care at the end of life. The authors highlighted that the root of this problem was a death-denying society and a nursing curriculum that primarily focused on the technology of death over the psychology of death (Fleming & Brown, 1983). This idea contrasts the themes apparent in the 1970s where psychological aspects of death were focused on in both medical and nursing curricula. Specifically, the authors ascribe this emphasis to the fact that curricula were focused on teaching nursing students how to monitor equipment and new technologies while less attention was placed on the social, cultural and spiritual needs of the patient and family (Fleming & Brown, 1983). Nursing schools were focused on teaching students the 'hands-on' skills and how to manage the different technologies in a rapidly advancing health care environment. What may be forgotten is how to engage in difficult conversations with patients and families and how to be helpful during stressful situations (Fleming & Brown, 1983). These interpersonal communications skills are key components to developing rapport with clients and developing trusting relationships with patients and their families.

In response to this gap in teaching about the psychosocial aspects of death and dying, this article presented the effects of a death education program consisting of didactic, role-playing,

and videotaped education sessions that offered insights about psychosocial topics including communication skills, emotional aspects of care, and providing culturally sensitive care at the end of life (Fleming & Brown, 1983). The authors highlighted the need for psychological care to be included in nursing curricula as the essential component to death and dying education. Their suggested program is one way to do this. Families are in vulnerable states when they lose a loved one so health care professionals might assist them best if they are able to talk with them about their needs and incorporate any cultural rituals that are important.

In a longitudinal quasi-experimental intervention study that evaluated a hospice course, two groups of baccalaureate school of nursing students were compared (Lev, 1986). This hospice course focused on cognitive, affective and psychomotor care of dying patients by evaluating the attitudes and behaviours of baccalaureate nursing students towards caring for dying patients (Lev, 1986). One group completed a course in hospice nursing while the control group did not receive a hospice education course. The purpose of this study was to measure the attitude of nursing students towards death and dying using the Colett-Lester fear of death scale and to determine the behavioral aspects focusing on avoidance behaviours using the Social Distance scale (Lev, 1986). Data was collected using pre and post-tests at the beginning and end of the course (Lev, 1986).

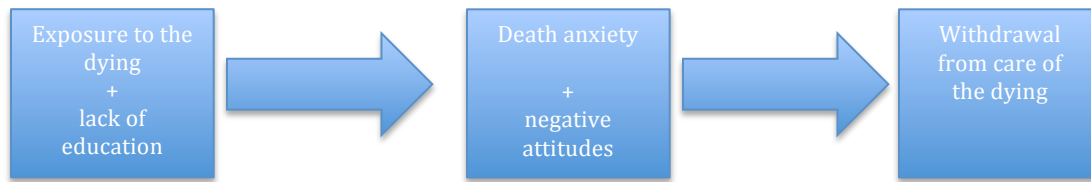
Results of the study showed a significant difference in the two groups with the students enrolled in the hospice course having lower death related fears and less avoidance behaviours and more positive behaviours in death related situations compared to the group who did not receive this education (Lev, 1986). The hospice course outlined the topics of physical, cognitive, and psychosocial changes in the dying which prepared students for providing holistic care for their patients (Lev, 1986). Further, knowledge about the physical changes in a dying patient

prepared nurses to recognize changes in health status and educate families that these are normal and expected with their deteriorating health condition.

Similar to the previous intervention study, a longitudinal quasi-experimental study conducted by Degner and Gow (1988a) compared two methods of teaching nursing students about death and dying by evaluating death anxiety and attitudes to care for dying patients as the two dependent variables. One group was taught using an integrated approach with varying amounts of clinical exposure and classroom teaching while another group was taught within an existing required course on death and dying that included planned clinical placements (Degner & Gow, 1988a). Students were divided into an experimental group, a nursing control group, and a non-nursing control group.

The theoretical model for this intervention study was adopted from Quint's influential research on how nurses care for the dying. Quint, a pioneer nursing scholar in palliative care was a social activist who detected the avoidance behaviours that physicians and nurses had with dying patients and their families (Ferrell, 2012). Specifically, Quint was involved in international group work on death, dying and bereavement as she was concerned with the lack of support patients and families had as they reached the end-of-life (Ferrell, 2012). Quint (as cited in Degber & Gow, 1988a) studied how nurses learned to care for dying patients and how they were influenced by their social environment. Quint's theory suggested that if nurses do not receive adequate education on death and are in situations where they are required to care for dying patients, their death anxiety coupled with negative attitudes led to withdrawal from caring for dying patients (Quint as cited in Degner & Gow, 1988a). This was a common observation Quint had when she worked in the palliative care setting. See Figure 3.1

Figure 3.1 Quint's theoretical model (Degner & Gow, 1988a, p. 161)



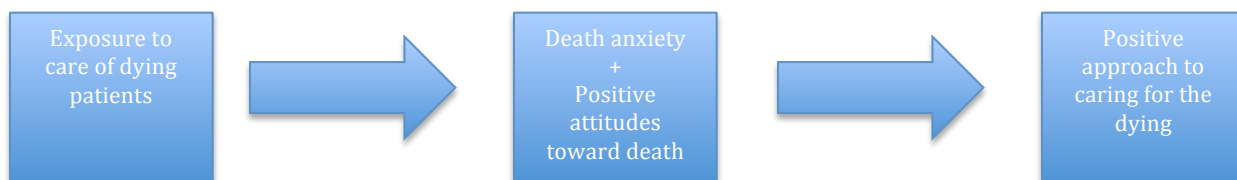
Students in the experimental group received a total of seventy two hours of course time in their junior and third year which focused on topics such as comfort care, palliative care, living with the dying, pain management, nutritional changes, body image, and bereavement (Degner & Gow, 1988a). The focus of these lessons was on psychosocial and physical changes that occur to people when they are nearing death. In addition to the in-class course content, students were assigned to four supervised clinical placements over two terms with six hours total each week. The focus of these clinical placements was to practice patient care in palliative, cancer care, extended care, and home care settings (Degner & Gow, 1988a). The practical experience within different health care environments would give students opportunity to apply their knowledge into practice and gain understanding of how dying patients are cared for in different settings.

Students enrolled in the nursing control group were involved in an integrative learning approach to death education. There was no specific semester in which death education was taught but the material was scattered throughout the four year nursing program. Approximately six hours of course material was dedicated to death education for the nursing curriculum (Degner & Gow, 1988a). The students in the non-nursing program received no death and dying education in their four-year program. The Collett-Lester scale was used to measure death anxiety while the Winget questionnaire was used to measure attitudes towards the dying patient and his family (Degner & Gow, 1988a). Degner and Gow (1988a) concluded that the experimental group felt their undergraduate program adequately prepared them to care for a dying person compared to the nursing control group and felt less anxiety in death related situations compared to the control

groups who received less or no formal education on the topics. Noticeably, the practical experiences were viewed as the most effective learning opportunities as students were able to apply the theory obtained in the classroom to real-life situations.

The quasi-experimental study made some recommendations for teaching death and dying topics to nursing students. The first recommendation was to encourage students to express their own ideas and feelings about death and examine their personal fears before they can help others (Degner & Gow, 1988a). This approach involved examination of the psychosocial aspects of death. The second recommendation was to ensure students have full exposure to patients who are dying by assigning them to care for two patients nearing death in both a hospital hospice or acute care setting and also in the home setting (Degner & Gow, 1988a). Interestingly, this seems to be a reiteration of similar advice given in the 1970s in the medical literature. Such clinical experiences were aimed at enabling students to implement the theory into practice and also work collaboratively with other health care professionals to meet patient and family centered needs. The conclusions lead to an important revision of Quint's earlier model. The revised theoretical model from this study underscored the notion that exposure to caring for dying patients coupled with positive attitudes about death will lead to a more positive approach to care for dying patients (Degner & Gow, 1988a). See Fig 3.2

Figure 3.2 Quint's revised theoretical model for death education
(Degner & Gow, 1988a, p. 167)



Similarly, in a follow up study by Degner and Gow (1988b), the integrative approach, elective course, and required course on death education were compared. The most popular method of teaching death education is the integrative approach as determined by a survey conducted in the United States and Canada with a total of two hundred and eight out of two hundred and thirty three schools using the integrative method of teaching. The integrative approach involved didactic lectures, videotapes, audiovisual materials and assigned readings to explore topics on grief, care of the dying, and family centered care (Degner & Gow, 1988b). A variety of teaching methods may help meet the needs of all students who may have different preferred learning styles. The popularity of the integrative approach was due to the flexibility of the program with each varying in topics covered and amount of time dedicated to the material. Significantly, a lack of interest from faculty to teach the topics of death was brought into focus as one of the challenges in finding appropriate instructors (Degner & Gow, 1988b). Faculty themselves do not feel prepared and comfortable talking about death and dying and therefore refrain from teaching these courses the authors revealed. These observations are one of the few direct references made in the literature review to the difficulties of teaching the topic of death and dying from an educator's perspective. While most of the research is concerned with student's attitudes and difficulties dealing with death, this study also discusses the lack of preparation faculty experience to teach the topic.

Another recommendation made from the findings of this study suggested offering an elective course on death education. Elective courses had content embedded in a systematic manner and offered more unique methods to teaching these topics including role-play and group exercises (Degner & Gow, 1988b). Although offering an elective course may allocate dedicated time to death topics and creative teaching strategies, it may be a course that lacks interest and

attention and may not be selected as a course amongst the student population if offered on an elective basis. No curricula evaluated in this study offered a mandatory course on death and dying education in their nursing programs.

The results of the study offered insights as to why teachers do not feel prepared to care for dying patients. One implication was the difficulty in teaching young people about death when they may have had no previous experience with death but are expected to care for patients in a sensitive manner during these times (Degner & Gow, 1988b). Young people may have never lost a loved one or close friend so they may not understand the emotions and changes that take place when someone is nearing death. In addition, health care professionals may be more inclined for curative-care rather than comfort-care models which makes caring for this population both stressful and emotionally draining (Degner & Gow, 1988b). Therefore, end-of-life situations may be unfamiliar and may take longer for health care providers to become comfortable with this aspect of care. Finally, death related subjects require both theory-based learning as well as experiential learning to teach these topics. Teachers may be limited by the clinical exposure that their students receive and teaching these aspects of care within a classroom can be a difficult task to undertake (Degner & Gow, 1988b).

One apparent theme in Degner and Gow's work is the notion of psychosocial care of patients and students. Death is a difficult topic to discuss and to teach. While the theories behind the dying process and physical changes can be taught in a classroom based environment, psychosocial aspects such as feelings, emotions, and personal experiences are best learned through therapeutic relationships with patients (Degner & Gow, 1988a; 1988b). The practical experiences assist students in applying their knowledge and performance of these skills may

increase their confidence and decrease their fears associated with the unknowns about death and dying.

A commonly used nursing fundamentals textbook is explored to identify changes and themes in regards to the material surrounding death and dying. Textbook analysis is essential to evaluate the extent of death related topics in nursing textbooks during this decade and to highlight differences from the previous textbooks explored (Kirchhoff, Beckstrand, & Anumandla, 2003). In a common nursing fundamentals textbook from 1987, a chapter titled “*caring and the human condition*” incorporates death education (Roach, 1987). In particular, the authors highlighted the problems that transcend in nursing curricula due to a death defying society. The author suggests that modern culture considers death unpleasant and therefore the denial of death is illustrated through making the corpse appear more life-like, protecting family members and loved ones from viewing the death event, and removing external signs of death (Roach, 1987). These examples showed how death is masked in efforts to hide the true realities of a dead person. The masking of death confirmed the fears and insecurities linked to the dying process and death in general. A recurrent theme from the textbook analysis showed that the physical aspects of death and psychosocial domains of care are often left out. These may be considered the difficult topics of discussion and may impact the way educators teach these topics. The silencing of death, particularly the physical aspects of death, in textbooks could in part be due to the overall avoidance of death in the culture. These topics may be left out all together in nursing curricula if they are not included in supplementary course textbooks.

New technologies that keep people alive longer may prolong the dying process and also impact the language used to describe the dying process. Interestingly, the textbook authors examined the choice of language used around death. Patients no longer “die” but “arrest” and the

choice of words adds to the denial and avoidance of death amongst health care professionals and families (Roach, 1987). This chapter does not include how death education should be taught or what topics are of importance for nursing students. No mention is made of the physical enactments of death and managing care of the dead body. These concepts were examined in detail in the textbooks analyzed from the 1970s.

3.5 Discussion

There are several themes from this decade that appear to be of interest in relation to death and dying education. One of these themes is the inclusion of systematic studies using theories, including the influential work of Quint, and examination of the way educational interventions impact death education. Literature from the selected articles revealed that using theoretical models as foundations to educational research as well as explicit educational interventions about death related topics helped students bridge the key concepts of death and dying into practice (Degner & Gow, 1988a). The theory-practice gap is another area of concern for nursing faculty and students as this affects patient care outcomes. Theories may help students better understand their roles and give meaning to the complexities that occur as a patient nears death. In particular, application of the stages of loss and grief may provide insight into the behaviours and psychosocial needs of patients and families during this difficult time (Armstrong, 1987). In addition, Degner and Gow (1988a) identified how the existing model on death education by Quint could be turned around into one that related educational interventions, such as a systematic course, to positive outcomes for students. Applying theories learned within the classroom to a practical setting is key to effective student learning (Degner & Gow, 1988a; Degner & Gow, 1988b; Perez et al., 1980; Smith et al., 1980). One method to bridge this theory-practice gap is through increased student-patient contact within the health care environment. Experiential

learning through patient contact and shadowing seasoned health care professionals enabled students to evaluate the realities of how death impacts patients and families (Degner & Gow, 1988a; 1988b; Smith et al., 1980). The combination of theory and practice and having a mixed lecture and clinical based method to teaching death related topics also helped meet the learning needs of students who may learn best with one method over the other.

There was a shift and expansion in the content included in death and dying education during the 1980s. In this decade, the focus of education was on comfort care, palliation, pain management at the end-of-life, nutrition, and body image changes (Degner & Gow, 1988a; 1988b). In the previous literature analyzed, the main focus was on psychosocial aspects of care and less on the enactments of how to care for a dead body with emphasis on post mortem care of the body. During the 1980s, the dying process including symptom management and physical changes seemed to gain renewed attention.

In the previous decade, patients were viewed as the most ideal teachers for students, whereas in the articles selected from the 1980s, health care professionals were deemed as the most appropriate teachers for students. Psychiatrists, nurses, physicians, and sociologists are some members of the interdisciplinary team that were used as teachers for death education as they have varied experiences in caring for this population (Perez et al., 1980). Patient contact was still stressed through clinical exposure but classroom teaching was conducted through faculty from different disciplines.

One similarity and recurrent theme from both decades is the way authors emphasized the importance of psychosocial care for patients and their loved ones. In particular, attending to the emotional needs and finding methods to include cultural practices of the patient helped nurses provide culturally sensitive family centered care (Degner & Gow, 1988a; Fleming & Brown,

1983; Perez et al., 1980) The repetition of this idea of psychosocial care may indicate that these authors seek to fill a gap in practice due to the overall avoidance of the psychological aspects of death and dying. This change in discourse may also have been part of the social influences involved with death and dying including recognizing patient and family wishes and needs (Armstrong, 1987). Exposing students to dying patients may decrease their fears and increase their confidence if they are able to talk about the feelings, emotions and unknowns they have about death and dying. As recommended by Degner and Gow (1988a), students must first come to terms with their own personal feelings and ideas about death before they can begin to help others. This idea is crucial for instructors to understand as having discussions about the psychosocial aspects of death and dying can impact student learning and ultimately improve patient outcomes.

CHAPTER 4: Integrated Model for Death and Dying Education

4.1 Introduction

During the 1990s, a great deal of literature emerged on the topics of death and dying. Death education received even more attention compared to the previous decades and was seen as an area that needed further exploration in nursing and medical curricula. In this decade, it was reported that many schools had some form of death education, either as an elective course or a class dedicated to discussions around death related topics embedded in larger death and dying courses. In the 1990s, nursing schools shifted to programs offering baccalaureate degrees and therefore a longer program seemed to encompass more time to teach these topics in a more structured curriculum.

There was a significant increase in the amount of nursing journals including literature on death related topics during the 1990s and into the 21st century compared to the previous decades. Several of the articles selected focused on the experiences of nursing students in caring for a dying patient with analysis of their attitudes, fears, and the effects of death education on patient care. Due to the increase in the number of scholarly articles for this decade, I have organized this chapter using sub-headings identifying the major themes. Some themes are recurrent from previous decades, whereas others are new topics. Since some of the articles explore more than one theme, they have been listed more than once in the table. These sub-headings are as follows: competencies; integrated death education model; systematic theory-based studies; patient as teacher; multidisciplinary team; and the avoidance of death. The recurrent themes from each of the decades explored thus far include the inclusion of theories to teach death related topics, patient contact to enhance student learning, and the avoidance of death in the culture at large. New themes evolving in this time period included the use of competencies to ensure consistency

in all curricula and a new emphasis on considering the socio-emotional fears of students who have personal experiences with death, particularly with conversation around grief and loss and how these concepts are related to death.

Table 4.1 Articles and textbook selected for review from the 1990s

<p>Competencies:</p> <p>Mermann, A. C, Gunn, D. B., & Dickinson, G. E. (1991). Learning to care for the dying: A survey of medical schools and a model course. <i>Journal of Academic Medicine</i>, 66, 35 – 38. doi: 10.1097/00001888-199101000-00010</p> <p>Downe- Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. <i>Death Studies</i>, 21(2), 177 – 188. doi: 10.1080/074811897202065</p> <p>Barnard, D., Quill, T., Hafferty, F. W., Arnold, R., Plumb, J., Bulger, R., & Field, M. (1999). Preparing the ground: Contributions of the preclinical years to medical education for care near the end of life. <i>Journal of Academic Medicine</i>, 74(5), 499 – 505. doi: 10.1097/00001888-199905000-00014</p>
<p>Integrated death education model:</p> <p>Dickinson, G. E. & Merman, A. C. (1996). Death education in U. S. Medical schools, 1975 – 1995. <i>Academic Medicine</i>, 71(12), 1348 – 1349. doi: 10.1097/00001888-199612000-00018</p> <p>Barnard, D., Quill, T., Hafferty, F. W., Arnold, R., Plumb, J., Bulger, R., & Field, M. (1999). Preparing the ground: Contributions of the preclinical years to medical education for care near the end of life. <i>Journal of Academic Medicine</i>, 74(5), 499 – 505. doi: 10.1097/00001888-199905000-00014</p>
<p>Systematic theory-based studies:</p> <p>Beck, C. T. (1997). Nursing students experiences caring for dying patients. <i>Journal of Nursing Education</i>, 36(9), 408 – 415. Retrieved from http://openurl.ebscohost.com.ezproxy.library.ubc.ca/linksvc/linking.aspx?genre=article&issn=0148-4834&date=1997&volume=36&issue=9&spage=408&atitle=Nursing%20Students%27%20Experiences%20Caring%20for%20Dying%20Patients&aulast=Beck</p> <p>Downe- Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. <i>Death Studies</i>, 21(2), 177 – 188. doi: 10.1080/074811897202065</p>

Kao, S. F. & Lusk, B. (1997). Attitudes of Asian and American graduates nursing students towards death and dying. *International Journal of Nursing Studies*, 34(6), 438 – 443. doi: 10.1016/S0020-7489(97)00038-2

Patient as teacher:

Mermann, A. C, Gunn, D. B., & Dickinson, G. E. (1991). Learning to care for the dying: A survey of medical schools and a model course. *Journal of Academic Medicine*, 66, 35 – 38. doi: 10.1097/00001888-199101000-00010

Knight, K. H. & Elfenbein, M H. (1993). Relationship of death education to the anxiety, fear, and meaning associated with death. *Death Studies*, 17(5), 411 – 425. doi: 10.1080/07481189308253386

Downe- Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies*, 21(2), 177 – 188. doi: 10.1080/074811897202065

Multidisciplinary approach to teaching:

Hill, L. J. & Stillion, J. M. (1995). An interdisciplinary undergraduate seminar: “Death and dying in psychology and theatre.” *Death Studies*, 19(4), 365 – 378. doi: 10.1080/07481189508252738

Dickinson, G. E. & Merman, A. C. (1996). Death education in U. S. Medical schools, 1975 – 1995. *Academic Medicine*, 71(12), 1348 – 1349. doi: 10.1097/00001888-199612000-00018

Downe- Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies*, 21(2), 177 – 188. doi: 10.1080/074811897202065

Avoidance of death:

Hurting, W. A. & Stewin, L. (1990). The effect of death education and experience on nursing students attitude towards death. *Journal of Advanced Nursing*, 15, 29 – 34. doi: 10.1111/j.1365-2648.1990.tb01669.x

Mermann, A. C, Gunn, D. B., & Dickinson, G. E. (1991). Learning to care for the dying: A survey of medical schools and a model course. *Journal of Academic Medicine*, 66, 35 – 38. doi: 10.1097/00001888-199101000-00010

Armstrong, P., Chooniere, J., & Day, E. (1st Ed.). (1993). *Vital Signs: Nursing in transition*. ON: Canada: Canadian Cataloguing in Publication Data.

Knight, K. H. & Elfenbein, M H. (1993). Relationship of death education to the anxiety, fear, and meaning associated with death. *Death Studies*, 17(5), 411 – 425. doi: 10.1080/07481189308253386

Kao, S. F. & Lusk, B. (1997). Attitudes of Asian and American graduates nursing students towards death and dying. *International Journal of Nursing Studies*, 34(6), 438 – 443. doi: 10.1016/S0020-7489(97)00038-2

Potter, P. A, & Perry, A.G. (1996). *Canadian fundamentals of nursing*. St Louis, Missouri: Mosby.

Textbook:

Potter, P. A, & Perry, A.G. (1996). *Canadian fundamentals of nursing*. St Louis, Missouri: Mosby.

4.2 Analysis of literature

The literature analyzed in this time frame has been organized thematically and chronologically in order to identify changes in death education over time. The chapter will conclude with an analysis of a commonly used nursing textbook during this decade and a historical analysis of nurses' work that notes changes in care of the dying. This will be followed by a discussion section highlighting the recurrent and emerging themes from the 1990s.

4.3 Competencies

In the 1990s, medical programs introduced competencies as guidelines for the way in which death related concepts should be included in the medical curriculum (Barnard et al., 1999; Mermann, Darlene, & Dickinson, 1991). Competencies ensured that students were learning the same material across schools in order to achieve entry-level competence in caring for dying patients. Key objectives for death education in relation to attitudes, knowledge, and skill were listed in order to develop medical school curricula in the United States. Meeting patient and family centered needs at the end-of-life involved knowledge, complex technical skills, and attitudes such as empathy and good listening. Expert palliative clinicians evaluated the identified competencies and learning objectives in order to validate the inclusion of death related topics in medical curricula.

The objectives encompassed the attitudes, knowledge and skills that were pertinent for all medical students before caring for dying patients (Mermann et al., 1991). The key concepts identified from the competencies included ensuring adequate symptom management for dying patients, collaborating with interdisciplinary team members to manage the complexities of patient and family needs, and assessing the whole patient from physical and psychosocial dimensions (Mermann et al., 1991). Providing holistic care for patients and families seemed to be a primary objective. The importance of open communication about death and dying and discussions about the natural part of the life cycle were also key elements for medical students to engage with when working with dying patients (Mermann et al., 1991). Although these learning objectives were specific to medical students in this study, they could be applicable to all health care professionals working with dying patients. The complexities of end-of-life care were revealed through the in depth list of all attitudes, knowledge, and skills a health care professional must incorporate when caring for this population.

In addition, Downe-Wambolt and Tamlyn (1997) also underscored crucial concepts related to death and dying in their exploratory study from Canada and the United Kingdom that were key recommendations for curriculum designers. The death related competencies they identified included student engagement with culturally competent care, the dying process, grief, hospice, terminal illnesses, and symptom control. These objectives were also echoed in the scholarly work of Barnard et al. (1999) who identified five dimensions of death and dying that are crucial for all students to learn.

Five core competencies were discussed amongst leaders in palliative medicine, educators, administrators, and policymakers at the National Consensus Conference on Medical Education for care near the end-of-life (Barnard et al., 1999). The five domains of death and dying

education included a) psychological, sociologic, culture and spiritual issues b) interviewing and communication skills c) management of common symptoms d) ethical issues and e) self knowledge and self-reflection (Barnard et al., 1999). These elements of death and dying education were viewed as the five vital domains necessary for all medical schools to include in their formal curriculum. The recommendations for competencies amongst all medical schools in the United States would promote consistency and quality care from practitioners.

Preferred methods to teach in the medical curricula across the United States included direct interaction with patients and families and role-play (Barnard et al., 1999). Conversing with patients who are suffering from life threatening illnesses encouraged students to empathize with the dying patient and provided opportunity for students to become aware of their own biases, fears and emotions. The emphasis on student-patient contact has been a recurrent theme from each of the decades explored in this study thus far. According to Barnard et al. (1999), role playing exercises created simulated experiences where students could enact the roles of patient, family, and doctor and practice the appropriate dialogue and practice their core competencies. Many of the core competencies including interviewing, communication, ethical issues, management of symptoms and self-reflection could all be practiced in these simulated scenarios (Barnard et al., 1999).

The use of competencies to guide student learning and help design curricula was a new concept during this time. Medical programs in particular noted competencies as providing more structure and consistency that was deemed essential for students to practice. The competency movement was adopted by medical and nursing disciplines alike as it aimed to improve patient outcomes with consistency, transferability of professional qualifications, and a more efficient health care workforce (Nelson & Purkis, 2004). With a rapidly advancing health care delivery

system and complexities involved in patient care, articulating the death and dying competencies helped to ensure the appropriate knowledge base needed for safe, patient centered care at the time of death. The use of competencies in nursing literature became more prominent in the 21st century.

4.4 Integrated death education model

Death education was beginning to receive more explicit attention in both medical and nursing curricula. However, while education on the dying process was deemed as necessary, due to an overcrowded curriculum, dedicated death and dying courses were seldom offered to students (Barnard et al., 1999; Dickinson & Mermann, 1996). Therefore, an integrated death education model was introduced as an alternative way for students to learn the content on death and dying within the existing courses.

Integration of death topics within existing courses within the medical curriculum encouraged students to make connections with how death was related to the various aspects of the care physicians provide as health care practitioners. For example, when students first dissected the human cadaver in anatomy class, instructors invited discussions about death fears, attitudes towards dying patients, and discussion surrounding the role of a physician (Dickinson & Mermann, 1996). Students would be given opportunity to also explore the social and psychological aspects of death by talking with their colleagues about their fears, emotions and personal experiences with death.

The integrated model to death education was likewise explored as an alternative to a dedicated course on death in one medical school (Barnard et al., 1999). Barnard et al. (1999) observed that it may be difficult to introduce a new curriculum on death and dying care to an already over packed schedule, therefore, it may be more useful for students to have courses or

lessons about death embedded within their other existing courses. For example, integration of end-of-life scenarios and death education in problem-based learning seminars, courses on ethics or behavioural sciences, and throughout clinical preceptorships would be ideal (Barnard et al., 1999). In particular, if a patient was nearing death, students could take these opportunities to engage with families and have conversations about the dying process and what is to be expected as the patient nears death (Barnard et al., 1999). This would provide them with scenarios to practice the appropriate dialogue and empathetic approach when talking about sensitive topics such as death. Similarly, during pharmacology class, students could learn about the physiology of pain and how this impacts indications, dosage calculations, and best routes of administration for people nearing death (Barnard et al., 1999). Students having opportunities to speak to their patients who suffered from life threatening illnesses and conversing with bereaved families provided opportunities for exploration into patient experiences and enabled students to build competence in managing end-of-life care. Barnard et al. (1999) use the notion of a “hidden curriculum” (p. 503) for medicine, which suggests the priorities of medicine and some of the underlying assumptions that students may experience. For example, the belief that medicine has the overwhelming power to cure is focused on so less emphasis is placed on end-of-life care and palliation of symptoms (Barnard et al., 1999). While students need to learn about how to help people improve their health, it is also vital for them to explore how they can help them die in dignity and comfortably.

Integrating death concepts within the current courses was seen as an effective alternative method to ensure that students learned about how death relates to their professional roles and how to competently care for dying patients (Dickinson & Mermann, 1996). Death concepts do

need to be discussed in detail, as there are many complexities of care with patients and their families.

4.5 Systematic theory-based studies

In the literature from the previous decade, there were some insights given on the application of theories to practice when caring for dying patients. In the 1990s, there is more discussion on theoretical models that impact care for a dying patient; specifically, the pioneering work of Patricia Benner and Elisabeth Kubler-Ross are examined (Beck, 1997; Downe-Wamboldt & Tamlyn, 1997; Kao & Lusk, 1997).

In a phenomenological study that explored the experience of nursing students caring for dying patients, Patricia Benner's "novice to expert" model was alluded to in describing how a novice nurse learned how to care for dying patients through mentorship from an expert nurse (Beck, 1997). Initially, mentorship began with the novice nurse, who may have no previous experience in caring for a dying patient observing the roles and responsibilities of the experienced nurse. The purpose of the mentorship program was to prepare nurses to take on roles gradually so that when they are working on their own, they were able to manage the care of a dying patient as they could draw on their previous experiences with the experienced nurse (Beck, 1997). As students transitioned from novice nurses to advanced beginners, they would gain knowledge and confidence in caring for dying patients independently. Mentorship was an effective way for students to practice their skills and feel supported from their colleagues.

In addition to educating students by working with expert nurses, another vital teaching tool used in nursing curricula was through debate, or structured conflict and controversies to enable students to manage ethical dilemmas (Beck, 1997). Students were placed in two groups and worked together to argue their view on the issue. Ethical dilemmas are common for end-of-

life situations nurses encounter. Often there are issues of honesty and truth telling between physicians, nurses, patients, and families, which creates more stress and tension in already difficult end-of-life scenarios. Practicing how to navigate these issues from an expert nurse and learning about ethical principles in nursing practice enabled novice nurses to work through these scenarios (Beck, 1997). Benner's theoretical model focused on the student and how they can best learn from their peers.

In contrast, Kubler-Ross' theoretical model explored the stages of grief and loss experienced by the patient and their loved ones (Downe-Wamboldt & Tamlyn, 1997). Downe-Wamboldt and Tamlyn (1997) discussed the importance of theory-based learning for death and dying education. Theories should be used as a foundation for designing death education curricula with Kubler-Ross' model on grieving as the most commonly used theoretical model within Canadian nursing and medical programs (Downe-Wamboldt & Tamlyn, 1997; Nelson & Purkis, 2004). The inclusion of theories helped guide the important topics that should be included within death education and gave students a common ground to develop their own practice. Kubler-Ross' stages of grieving include denial, anger, bargaining, depression and acceptance (Downe-Wamboldt & Tamlyn, 1997). It was suggested that knowing the various stages that patients and families may experience may be useful for the interdisciplinary team so that they can be prepared to help both patients and their families by providing the appropriate information and collaborating with other members of the health care team. This is one key element to providing psychosocial support to all stakeholders involved with the dying patient and ensuring care is carried out in a culturally sensitive manner.

Kao and Lusk (1997) explored the influence of culture on perceptions and attitudes toward death among students. The notions of grief and loss were expressed in various ways and

can be impacted by cultural norms. In a study comparing the attitudes of Asian and American graduate nursing students, cultural differences related to death and dying were highlighted (Kao & Lusk, 1997). In the American culture, students reflected an egalitarian view in which ethical principles of autonomy, justice and emotions were openly expressed when working with patients who are dying (Kao & Lusk, 1997). Death education was included within American nursing programs so that students could gain death-related experiences before entering the nursing workforce. Conversely, in the Asian culture, communication was often indirect and conversations about death with the dying were viewed as unethical (Kao & Lusk, 1997). These cultural norms are portrayed through the avoidance of death related topics in nursing programs offered to students in Asia, as nurses do not participate in any family and physician discussions about dying patients. Both cultural views have an immense impact on how patients and families experience death.

Kao and Lusk (1997) hypothesized that graduate nurses from Asian nursing schools would be more anxious about caring for dying patients compared to American nursing students. Results from the questionnaires indicated that Asian graduate nurses had significantly more fear about their own death, uncertainty with the death process, and dying alone compared to American graduate nurses (Kao & Lusk, 1997). These fears correlated with a death adverse Asian society and complete dismissal of these topics during nursing training. In addition, these fears about the dying process may promote avoidance behaviours in nurses due to having unknowns about the dying process and lack of practice. In particular, nurses reported avoiding conversation, speaking only when spoken to by the patient, and only talking to patients about topics that were comfortable for the nurse (Kao & Lusk, 1997). Cultural norms have a strong impact on the care that is provided to patients as they near death. This study highlighted the

norms and beliefs of people of Asian backgrounds that affect how death is perceived and ultimately impacts patient care.

The theoretical application in death education impacted the manner in which death and dying were understood during this time. Theories were also emerging in nursing textbooks that examined Kubler- Ross's theory on grief as it was commonly used in Canadian nursing textbooks (Potter & Perry, 1997). The insights from the scholarly work of Benner and Kubler-Ross helped health care professionals appreciate the stages of growth as a novice to expert nurse and also grasp the manner in which people may experience loss and grief (Beck, 1997; Downe-Wamboldt & Tamlyn, 1997). Each individual experiences loss in a unique way so therefore knowing the various stages can help direct health care professionals in finding the appropriate resources for patients and their families.

4.6 Patient as teacher

A recurrent theme in the literature examined thus far is the need for students to have experiential learning opportunities and the explicit attention given to patients as teachers for students (Downe-Wamboldt & Tamlyn, 1997; Knight & Elfenbien, 1993; Mermann et al., 1991). Patient contact and experiential learning were effective methods for students to apply their knowledge in a practice setting (Mermann et al., 1991). Medical schools examined in this study preferred to use the patient as teacher model to educate their students on death and dying processes (Mermann et al., 1991). Direct patient contact provided students opportunity to converse with patients and talk about their stories. Patients elaborated on their personal experiences and fears associated with their terminal illnesses and spoke about challenges, experiences with physicians managing their disease, and informed students of their idea of a good doctor (Mermann et al., 1991). The patient-teacher model provided students with an in

depth understanding of the various emotions of a sick patient and the immense impact a physician and other healthcare professionals have on their life. This was perceived to be one of the best ways for student learning to take place and for medical students to gain practice in the essential communication piece when providing care to dying patients.

Knight and Elfenbien (1993) and Downe-Wambolt and Tamlyn (1997) similarly described the advantages of student-patient contact. Students visited cancer patients with progressive illnesses in the hospital where they were able to identify the specific needs that dying patients had and acknowledged their fears associated with dying (Knight & Elfenbien, 1993). In this context, students could build rapport with patients and practice their active listening skills by engaging with patients and their families. Hospital visits with cancer patients also helped alleviate the anxiety students had with communicating with dying patients and provided insight into how the patient is impacted by their terminal illness (Knight & Elfenbien, 1993). The importance of clinical contact with patients was identified as key to the development of student competence (Downe-Wambolt & Tamlyn, 1997). Patient exposure was found to be the best way for students to learn about the real experiences that these individuals had with death and dying.

4.7 Multidisciplinary team

The multidisciplinary approach is explored as an effective method to teach death and dying topics to medical and nursing students (Dickinson & Mermann, 1996; Hill & Stillion, 1995). Educators from an alternative health care profession than the profession of the students promoted professional bonding and team building (Dickinson & Mermann, 1996). A unique form of teaching about death and dying was illuminated through the interdisciplinary course offered by instructors from two different disciplines where dramatic literature was used to examine the psychological concepts surrounding death (Hill & Stillion, 1995). The purpose of

the course was to integrate learning about death through the perspectives of psychology and theatre so that students acknowledge concepts from both disciplines and learn from instructors from a different professional background than their own. The instructors focused on team-teaching rather than turn-teaching in which both attended and planned each class agenda together (Hill & Stillion, 1995). The five main concepts highlighted within the course included facing death, finding meaning to death, examining AIDS, suicide across a lifespan and death and loss (Hill & Stillion, 1995).

Students were responsible for reading through nine plays that exemplified various psychological principles associated with the dying process. For example, the play Hamlet was used in this course as the theme represented the grieving process that aligns with the course material (Hill & Stillion, 1995). In addition, Hill and Stillion (1995) suggested that the play Antigone was used in this course, as it is a striking example of the strength endured by families during an unexpected death. The play exercises were designed to encourage students to integrate the course content into an interactive affective display of their learning. Student and faculty review upon completion of the course showed positive outcomes from the integrative course. Faculty appreciated working in tandem with someone from a different profession than their own, learning each other's perspectives, and developing new teaching styles (Hill & Stillion, 1995). This idea of team-teaching could be beneficial for other instructors teaching courses on death. Student reviews revealed positive outcomes from learning from the views of two professors from different academic backgrounds and appreciated learning about the sensitive topic of death through plays and theatre (Hill & Stillion, 1995). Theatre brought out the same themes surrounding death and assisted students in exposing their fears and feeling the emotions

associated with the dying. In this study, two instructors from theatric and psychology professions together taught a course on death through theatre.

Dickinson and Mermann (1996) also revealed the advantages of student learning from professors across different areas of expertise. Instructors from various health care backgrounds teaching a death education course is beneficial to students who learned from the experiences and adapted different perspectives to patient care. Furthermore, students benefited from learning about the roles and responsibility of all members of the health care team as managing end-of-life situations involved a team-oriented approach (Dickinson & Mermann, 1996). This method promoted interprofessional collaborating and enhanced communication amongst all health disciplines.

On the other hand, Downe-Wambolt and Tamlyn (1997) suggested that using professionals from their own discipline to teach topics on death and dying increased depth of knowledge and continuity of content. Furthermore, focusing on their own roles and responsibilities could help students identify the impact they have on patient care. Instructors could also potentially share their own personal stories and experiences with their students, which could help increase their awareness on their professional responsibilities. Having an instructor of the same discipline throughout the entire course eliminated the possibility of role confusion and promoted student rapport building with their instructors (Downe-Wambolt & Tamlyn, 1997). As students can be overwhelmed with knowledge and information during training, it is evident why specifically focusing on one professional role might be advantageous. In addition, having an instructor experienced in the same professional role may prevent important information from being missed.

4.8 Avoidance of death

The overall avoidance of death is a recurrent theme across each decade examined in this study (Hurtig & Stewin, 1990; Kao & Lusk, 1997; Knight & Elfenbien, 1993; Mermann et al., 1991; Potter & Perry, 1997). There appears to be recognition in scholarly literature that death and dying are topics that need more attention; however, this sense of avoidance and separation from dying patients still continues to exist.

Hurtig and Stewin (1990) argued that death anxiety was one of the major reasons for the separation that nurses and other health care professionals had with dying patients. In an experimental study that surveyed nurses, Hurtig and Stewin (1990) discovered that hands-on exercises with students engaging in group discussions, music, simulation, drawing and dyadic student meetings led to increased confidence and reduced death anxiety compared to the group of students who used traditional didactic learning methods. Practicing the concepts learned within the course in a simulated scenario provided a safe environment for student learning to take place where patient care was not jeopardized. Furthermore, simulation enabled students to re-do scenarios to include any feedback and improvements based on group discussion and self-reflection (Hurtig & Stewin, 1990). Students received immediate feedback from their peers and could revisit the death and dying scenarios.

Death has been associated with failure in a cure-focused profession (Mermann et al., 1991). Health care professionals are often concentrated on fixing the problem and may associate a dying patient with personal defeat (Mermann et al., 1991). This idea coupled with a technologically sound health care environment where life can be prolonged with advanced machinery made death difficult to acknowledge. Mermann et al. (1991) proposed that medical schools are packed with scientific knowledge and less time is devoted to mastering important

skills such as talking about emotions and learning how to communicate difficult conversations with families. Communication is an integral part of the role of the physician and therefore these key skills must be mastered before entry into practice.

A new idea explored by Knight and Elfenbien (1993) and Hurtig and Stewin (1990) underscored that death and dying education may potentially increase student anxiety surrounding death, rather than decreasing their fears. Students who have had previous experiences with death or been personally affected by the death of a loved one may have a difficult time learning about death related concepts (Knight & Elfenbien, 1993). These socio-emotional factors associated with loss and grief have not sufficiently been explored up until this point. The implications for nursing education indicate that students with previous experiences with death may benefit from a more didactic approach to learning about death, as it is less intensive than a hands-on approach (Hurtig & Stewin, 1990). However, inexperienced student learning about death through experiential methods would provide them opportunity to grasp concepts in a more interactive way and gain awareness of the complexities surrounding death (Hurtig & Stewin, 1990). It is unclear in the literature as to how instructors would manage a situation where a student is personally affected by death. Students with previous experiences with death may still be struggling with the grieving process so this concept needs further exploration. Death education, up until this decade has been viewed as a separate phenomenon to grief and loss. It is important that these students are able to express their personal emotions, fears and stories, if it is deemed therapeutic for them. The idea of grief and loss in relation to death and dying is given specific attention in the next chapter.

Kao and Lusk's (1997) study on the influence of culture on death perceptions is also relevant to the theme of avoidance. Exploring how culture affects that manner in which death is

understood, Kao and Lusk (1997) contend that cultural practices and norms may lead to avoidance of death related topics, specifically to Asian cultures. Unspoken fears coupled with uncertainty about the death process lead to avoidance behaviours in nurses where nurses only talk to patients about topics that they are comfortable with (Kao & Lusk, 1997). A lack of understanding and communication about personal fears and anxieties surrounding death made it difficult for a change in a death-adverse culture.

Similarly, in a nursing textbook, the importance of open communication through frequent, clear, truthful discussions with patients and families about their condition was emphasized (Potter & Perry, 1997). Potter and Perry (1997) dedicate an entire chapter on therapeutic communication and how this is integral to patient care, especially at the end of life. The increased attention to open communication and therapeutic communication principles could be aimed at identifying this avoidance to communicate about the psychosocial aspects of death and dying and to fill a gap in practice amongst health care professionals.

4.9 Textbooks

One popular Canadian fundamental in nursing textbook was evaluated for the inclusion of death and dying concepts and recommendations for death and dying education for nursing students (Potter & Perry, 1997). Several chapters in the textbook highlighted topics pertinent to death education including communication, ethics, legal issues, teaching and learning, stress and adaptation, coping with loss, death and grieving, spiritual health, the older adult and comfort. A separate chapter was devoted to death and grieving and explored in detail the key roles of nurses in assisting clients with problems related to loss, grief and death and how a nurse can best meet the dying patients needs for comfort and caring (Potter & Perry, 1997). Again, this new focus on

loss and grief was starting to emerge and there was explicit attention in these concepts within the nursing textbook analyzed in this decade.

In addition, theories commonly used by nursing scholars were brought into focus in this chapter. Specifically, Kubler-Ross' and Rando's theories on the grieving process are described (Potter & Perry, 1997). Yet, as mentioned, several other chapters are relevant to the nurse's roles and responsibilities at the time of death. For example, there is an entire chapter dedicated to therapeutic communication and the importance of open communication through frequent, clear, truthful discussions with patients and families about their condition (Potter & Perry, 1997). Furthermore, ethical issues are common at the end-of-life with varying ideas and viewpoints from family, patients and members of the health care team. The ethics chapter in the textbook identified key principles to maintain when working through difficult ethical scenarios and being knowledgeable about resources such as ethics boards available within the health care setting to help with these situations (Potter & Perry, 1997). There is a great deal of information in this textbook that could be helpful to nurses dealing with difficult end-of-life situations and can also impact the topics that are taught within nursing curricula.

4.10 Discussion

The key findings from the selected literature from the 1990s revealed a shift in how death and dying education was structured and incorporated within nursing and medical curricula including the use of core competencies and an integrated model for incorporating death education into existing courses. The use of competencies and key concepts to ensure consistency amongst nursing and medical students learning about topics related to death and dying was a new phenomenon presented during this decade (Barnard et al., 1999; Downe- Wamboldt & Tamlyn,

1997; Mermann et al., 1991). The explicit discussion of the use of competencies, however, was primarily seen in scholarly literature from medical journals during this decade.

Competencies served to define key course concepts and elaborated on the fundamental skills students must have to care for a dying patient. These competencies included psychosocial care, cultural competence, communication skills, symptom management, and ethics issues (Barnard et al., 1999; Downe- Wamboldt & Tamlyn, 1997; Hill & Stillion, 1995). When students entered their practice and obtained positions in the health care environment, they would benefit from learning the same information and having the same training across programs. This idea of consistency of knowledge-base and performance within the health care setting was examined by Nelson and Purkis (2004) who argued that these were key elements to defining competence or being qualified to practice safely. Consistency amongst nurses and physicians could have the potential to improve patient outcomes if everyone was educated and knowledgeable about the same core competencies of death and dying care.

The integrated model was most consistently used to blend topics related to death and dying into other existing courses. Integration of death education enabled students to learn how death and dying related to other courses and impacted the many aspects of care they provide such as through pharmacology, communication lectures, and through their ethics courses (Barnard et al., 1999; Dickinson & Mermann, 1996). One excellent example provided by Dickinson and Mermann (1996) highlighted how the first dissection of the human cadaver was used as a prime learning opportunity for students to discuss their death fears, attitudes towards a dying patient and integrate how these feelings affect their roles as a physician and health care provider. Interestingly, this same example was alluded to in the 1970s when Barton (1972) examined how the psychological autopsy could be used as a prime teaching opportunity to explore the fear and

anxieties that students have surrounding death. Nursing and medical curricula are often overloaded with too much information and have little room to introduce new courses. The integrated model, therefore, is an effective way to include information about death and dying within the existing courses of the curriculum. This could also potentially impact the attitudes of instructors who may not otherwise want to teach a death and dying course but may increase their interest in teaching integrated courses.

There are a few persistent themes that have been brought into focus throughout each decade analyzed thus far. These themes include the notion of care versus cure and the importance of patient contact for experiential learning (Barnard et al., 1999; Downe- Wamboldt & Tamlyn, 1997; Mermann et al., 1991). Palliative care, hospice and end-of-life care invited new ways of thinking about patient care. While medical disciplines may be driven and taught to believe their role as professionals is aimed at “fixing” patients and curing them so they are free of their illness, it may not always be the appropriate form of care when people near the end-of-life. Caring for patients who are nearing death, therefore, opens up windows of comfort care and ensuring patients are pain free. It appears that over this decade, there is a shift to inclusion of comfort care along with the curing aspects of medicine (Barnard et al., 1999; Mermann et al., 1991). Patient contact is still considered central to learning about one’s experience with dying. It is evident why clinical experience is a recurrent topic through each decade as well as in the previous decades examined for this study. Specifically, cancer patients are used as prime examples of patient that students should be exposed to, especially those who may have a terminal illness. Their personal stories, fears and emotions related to dying are an essential source of learning for students (Downe-Wamboldt & Tamlyn, 1997; Knight & Elfenbien, 1993; Mermann et al., 1991). These

authors reiterate how the patient as teacher model can increase student awareness of the psychosocial impact that death has on the patient and their loved ones.

One new unique method of teaching death and dying education is explored through play right and acting (Hill & Stillion, 1995). This idea of using plays to explore the complex issues surrounding death and dying is one that has not been mentioned previously. Hill and Stillion (1995) argued that plays could conjure up many images and feelings associated with psychosocial principles related to death. In particular, play exercises encouraged students to bring to life the emotions and feelings associated with an unexpected death and display their learning in an interactive manner.

In the 1990s, new dialogue on loss and grief is presented in relation to death and dying (Hurtig & Stewin, 1990; Knight & Elfenbien, 1993; Mermann et al., 1991; Potter & Perry, 1997). Students with previous experiences with death or those who have lost a loved one must be considered when educators address death and dying concepts to this population. Death education, to this point in the literature was viewed as separate to the grieving process. Now, during the 1990s, we begin to see a shift with the inclusion of Kubler-Ross' theories on grief and loss and consideration of the psychosocial needs of students (Downe-Wamboldt & Tamlyn, 1997; Hurtig & Stewin, 1990; Potter & Perry, 1997). An example in the literature identified the experience of one student who had recently lost her mother to cancer and the course content on death and dying increased her death anxiety as it reminded her of the pain associated with losing her mother (Knight & Elfenbien, 1993). Although this article examined the experience of one student, it is likely that many other students may have experienced the loss of a loved one. Yet, no mention had been made in the literature up until this point on how educators need to consider

the needs and anxieties of these particular students. This notion of the grieving process is given more attention in the 21st century and will be discussed in the next chapter.

CHAPTER 5: The Emergence of a Focus on Grief and Loss

5.1 Introduction

Review of the literature from the year 2000 onwards reveals another substantial increase in publications on death and dying in scholarly journals. While a large amount of this literature focuses on student learning and their experiences in dealing with death and dying, a substantial number of scholarly work centers on death education and questions of pedagogy, course delivery and curriculum development (Cavaye & Watts, 2014). In addition, discussions of death and dying in textbooks also increased. During this time period, technological advancements were made within the health care environment that prolong life and impact the manner in which death relates to patients, families and health care professionals (Hadders, 2009). The use of technology also impacts the manner in which nurses enact death and dying. In addition, new ideas about death and dying including palliation and hospice were topics receiving more consideration, as were the notions of grief and loss (Wass, 2010). New attention is given to a multidisciplinary approach which resulted in shifts in death and dying care, education of health care professionals, and patient and family-centered care (Fineberg, Wenger, & Forrow, 2004). Online learning and use of educational technology such as simulation also receive more attention within this decade.

It is vital to recognize the difference in the number of selected articles from 2000 onwards compared to those previously described as an indication of the increase in death and dying literature. The baccalaureate programs in nursing have been well established by this time and many journal articles include reflections on death and dying related learning experiences provided to nursing students during their training. Although there is an abundance of literature from this time frame, using the search terms as indicated, the following twenty-three articles on death and dying education were selected for review for this time period.

Similar to the previous chapter, I have organized this chapter using sub-headings for the emergent themes from the literature explored. These headings will be as follows: death education courses, competencies, online learning, care for the dead body, teamwork, and educators. The concepts of online learning, enactments of dead body care, death education through online learning and the use of competencies are all recurrent themes from the previous decades. Competencies are alluded to in many scholarly articles as being the ideal method to ensure consistency of learning amongst students in nursing programs (Kirchhoff, Beckstrand, & Anumandla, 2003; Paice et al., 2006; Thompson, 2005). Although loss and grief were examined in the previous decade, specific attention is now given to how loss and grief relate to death and dying in this chapter.

Table 5.1 Articles and textbooks selected for review from year 2000 onwards

Death education courses:

Birkholz, G., Clements, P. T., Cox, R., & Gaume, A. (2004). Students self-identified learning needs: A case study of baccalaureate students designing their own death and dying course curriculum. *Journal of Nursing Education*, 43, 36 – 39. Retrieved from <http://web.a.ebscohost.com.ezproxy.library.ubc.ca/ehost/detail/detail?sid=63d8b9ed-dd8e-4a53-8731-c6e52e409fad%40sessionmgr4001&vid=0&hid=4206&bdata=JnNpdGU9ZWhtvc3QtbGl2ZSZzY29wZT1zaXRl#db=eue&AN=507876017>

Thompson, G. T. (2005). Effects of end-of-life education on baccalaureate nursing students. *Journal of the Association of Perioperative Nursing*, 82(3), 434 – 440. doi: 10.1016/S0001-2092(06)60339-6

Dickinson, G. E. (2007). End-of-life and palliative care issues in medical and nursing schools in the United States. *Death Studies*, 31(8), 713 – 726. doi: 10.1080/07481180701490602

Johnson, A., Chang, E., & O'Brien, L. (2009). Nursing the dying: A descriptive survey of Australian undergraduate nursing curricula. *International Journal of Nursing Practice*, 15, 417 – 425. doi: 10.1111/j.1440-172X.2009.01790

Simulation:

Dickinson, G. E. (2007). End-of-life and palliative care issues in medical and nursing schools in the United States. *Death Studies*, 31(8), 713 – 726. doi: 10.1080/07481180701490602

Leighton, K. & Dubas, J. (2009). Simulated death: An innovative approach to teaching end-of-life care. *Clinical Simulation in Nursing*, 5(6), 223 – 230. doi: 10.1016/j.ecns.2009.04.093

Moreland, S. S., Lemieux, M. L., & Myers, A. (2012). End-of-life care and the use of simulation in a baccalaureate nursing program. *International Journal of Nursing Education Scholarship*, 9, 1 – 16. doi: 10.1515/1548-923X.2405

Competencies:

Kirchhoff, K., Beckstrand, R. L., & Anumandla, P. R. (2003). Analysis of end-of-life content in critical care nursing textbooks. *Journal of Professional Nursing*, 19(6), 372 – 381. doi: 10.1016/S8755-7223(03)00141-8

Thompson, G. T. (2005). Effects of end-of-life education on baccalaureate nursing students. *Journal of the Association of Perioperative Nursing*, 82(3), 434 – 440. doi: 10.1016/S0001-2092(06)60339-6

Paice, J. A., Ferrell, B. R., Virani, R., Grant, M., Malloy, P., & Rhome, A. (2006). Graduate nursing education regarding end-of-life care. *Nursing Outlook*, 54, 46 – 52. doi: 10.1016/j.outlook.2005.04.003

Wallace, M., Grossman, S., Campbell, S., Robert, T., Lange, J., & Shea, J. (2008). Integration of end-of-life care content in undergraduate nursing curricula: Student knowledge and perceptions. *Journal of Professional Nursing*, 25, 50 – 56. doi: 10.1016/j.profnurs.2008.08.003

Todaro-Franceschi, V. (2011). Changing the face of death: A pedagogic intervention. *Journal of Professional Nursing*, 27(5), 315 – 319. doi: 10.1016/j.profnurs.2011.04.002

Weissman, G. V. (2011). Evaluating associate degree nursing students self-efficacy in communication skills and attitudes in caring for the dying patient. *Teaching and Learning in Nursing*, 6(2), 64 – 72. doi: 10.1016/j.teln.2010.10.004

Online learning:

Kavanaugh, K., Andreoni, V. A., Wilkie, D. J., Burgener, S., Buschmann, M. B., Henderson, G., Hsiung, Y. Y., & Zhao, Z. (2009). Developing a blended course on dying, loss, and grief. *Nurse Educator*, 34(3), 126 -131. doi: 10.1097/NNE.0b013e31819fcad1

Todaro-Franceschi, V. (2011). Changing the face of death: A pedagogic intervention. *Journal of Professional Nursing*, 27(5), 315 – 319. doi: 10.1016/j.profnurs.2011.04.002

Care of the dead body:

Blum, C. A. (2006). “Till death do us part?” The Nurse’s role in the care of the dead. *Journal of Geriatric Nursing*, 27, 58 – 63. doi: 10.1016/j.gerinurse.2005.12.004

Hadders, H. (2007). Dealing with the dead patient at the intensive care unit. *Mortality*, 12(3), 207 – 222. doi: 10.1080/13576270701430726

Hadders, H. (2009). Medical practice, procedure manuals and the standardization of hospital death. *Nursing Inquiry*, 16, 22 – 32. doi: 10.1111/j.1440-1800.2009.00427.x

Hadders, H. (2009). Enacting death in the intensive care unit: Medical technology and the multiple ontologies of death. *An Interdisciplinary Journal for the Social Study of Health, Illness, and Medicine*, 13(6), 571 – 587. doi: 10.1177/1363459308341869

Pattison, N. (2008). Caring for patients after death. *Nursing Standard*, 22(51), 48 – 56. Retrieved from <http://web.a.ebscohost.com.ezproxy.library.ubc.ca/ehost/detail?sid=47a8e29e-f096-4a57-a89a-78bbc9a7a7e5%40sessionmgr4001&vid=1&hid=4209&bdata=JnNpdGU9ZWVvc3QtbGl2ZSZzY29wZT1zaXRI#db=c8h&AN=2010035481>

Teamwork:

Cavaye, J. & Watts, J. H. (2012). End-of-life education in the pre-registration nursing curriculum: Patient, carer, nurses and student perspectives. *Journal of Research in Nursing*, 17(4), 317 – 326. doi: 10.1177/1744987110379531

Fineberg, I. C., Wenger, N. S., & Forrow, L. (2004). Interdisciplinary education: Evaluation of a palliative care training intervention for pre-professionals. *Academic Medicine*, 79(8), 769 – 776. doi: 0.1097/00001888-200408000-00012

Educators:

Mallory, J. L. (2003). The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *Journal of Professional Nursing*, 19(5), 305 – 312. doi: 10.1053/S8755-7223(03)00094-2

Wass, H. (2010). A perspective on the current state of death education. *Death Studies*, 28(4), 289 – 308. doi: 10.1080/07481180490432315

Textbooks:

Morton, P. G., Fontaine, D. K., Hudak, C. M., & Callo, B. M. (8th Ed.). (2005). *Critical care nursing: A holistic approach*. Philadelphia: PA: Lippincott Williams & Wilkins.

Potter, P. A., Perry, A. G., Ross-Kerr, J. C., & Wood, M. J. (3rd Ed.). (2006). *Canadian fundamentals of nursing*. Toronto, ON: Elsevier.

5.2 Analysis of literature

The literature analyzed in this decade is organized chronologically in order to identify the changes in death education over time. In addition, the articles are organized similar to the previous chapter with sub-headings identifying the themes. The chapter will also include analysis of two commonly used nursing textbooks for this time period and will end with a discussion on the new themes as well as the recurrent themes from the previous decades. The recurrent themes are the use of patients as teachers, simulation based learning, and the used of a team-oriented approach to providing patient centered care. The new themes from this time period include online learning as a new method used to teach death topics and also the emergence of grief and loss in nursing literature.

5.3 Death education courses

Several authors describe the delivery of specialized courses in death education. Death education courses have been organized in many different ways and many examples have been provided as the best methods to teach students about death related subjects. These methods include experiential learning, didactic learning, and integration of topics within existing courses (Birkholz, Clements, Cox & Gaume, 2004; Dickinson, 2007; Johnson, Chang, & O'Brien, 2009).

A persistent theme throughout the period under study is the importance of experiential learning through patient contact, this theme is also highlighted in previous decades. Moreover, in

this decade, it seems the most recommended method for students to learn about death and dying principles (Birkholz et al., 2004; Dickinson, 2007; Johnson et al., 2009; Thompson, 2005;). It is suggested that clinical exposure promotes socialization into the workplace and increases student awareness of how their role impacts patient care. Further, supervised clinical experiences are found to be essential to student learning as they provide learning opportunities within the health care environment through direct patient and family contact (Birkholz et al., 2004; Dickinson, 2007). Dickinson (2007) reveals that hospice visits are used as a learning tool in nursing and medical schools as students are able to practice communicating with dying patients and explore the patient's story. The best learning may occur as students apply their knowledge and visualize what it means to care for a dying patient. The clinical experience recommendations include a preconference discussion and planning of clinical experience, observing a hospice nurse, an instructor-led clinical experience, and post-conference discussion on learning outcomes (Thompson, 2005). Clinical exposure is also a recommended method to student learning because students are able to apply their theoretical knowledge into practice in a palliative care setting or an environment where they would encounter a patient at the end of their life (Johnson et al., 2009). Experiential learning helps to bridge the theory-practice gap and boosts student confidence in managing end-of-life situations. The clinical exposure helps students solidify the course material and apply the core concepts into their practice.

Other experiential learning opportunities explored in this decade are through didactic learning and through the integration of topics within existing courses. Students value journaling as a way to reflect on classroom content and express their thoughts about classroom activities (Birkholz et al., 2004). Journaling after a class could also give students opportunities to reflect on the material they learned and perhaps bring new questions and ideas to the following class. Other

experiential activities include writing a personal advanced directive form, observing an autopsy, touring a mortuary, attending hospice orientation, and completing a hospice home visit with an experienced nurse (Birkholz et al., 2004). These learning approaches enhance the communication skills of students through a variety of case scenarios. Barriers to effective communication and good patient care are also identified through case scenarios (Birkholz et al., 2004). Experiential learning through observation of autopsy and hospice home visits provide opportunities for students to learn from patients who are dying and explore what happens to the dead body after it leaves the ward. Similar to what has been argued about experiential learning during the previous decades, these experiences are considered necessary for students to obtain during the learning stages of death education.

Dickinson (2007) also expresses the need for experiential and didactic learning opportunities for students through role playing, small group discussions, and simulation. According to Dickinson (2007), nursing and medical schools offer death education courses for an average of twelve to fourteen hours in total per curriculum with less than 1/5 of nursing and medical and nursing schools offering a full time course on death and dying education, a static that has historically existed. Both professions most commonly use the lecture method to teach death topics and also small group discussions to elaborate on these topics (Dickinson, 2007). Dickinson (2007) reveals that hospice visits are used as learning tools in 2/5 of the nursing and medical schools where students communicate with dying patients and learn from their personal experiences. Other learning tools used in medical schools include simulation and role-playing where students would enact the roles of patient, family and caregiver (Dickinson, 2007). The author suggests that more information is needed on the effectiveness of having professionals from other disciplines teach the topics of death and dying (Dickinson, 2007). It needs to be

explored whether exposure to teachers from different disciplines enables students to learn different perspectives and gain understanding of the roles and responsibilities of different members of the health care team. The goal of death education should be to prepare nurses and medical students to comfortably educate patients and families about the dying process (Dickinson, 2007). Acknowledging personal fears, practicing how to communicate with dying patients, and supporting bereaved family members can achieve this.

Similarly, as observed in the previous decade, the integrated model of death education was considered as an effective way to incorporate death concepts into an existing curriculum. Issues related to the lack of attention given to death and dying education within nursing curricula include an already overcrowded curriculum, lack of confidence by faculty to teach these difficult topics, and lack of priority from curriculum designers who may view death education as low priority (Johnson et al., 2009). These same issues were presented in the previous decade by Dickinson and Mermann (1996) and Barnard et al. (1999) who argued that an over-packed scheduled made it difficult to introduce new courses on death and dying concepts. The integration of death concepts within an existing course could be one solution to this consistent problem of an overcrowded curriculum. Incorporating these concepts within other courses promoted further student engagement in identifying how death impacts the many roles and responsibilities that they have as professionals (Johnson et al., 2009). While hands on practical experience may be the most effective way to teach students, few efforts have been made to find student planned clinical placements in palliative care (Johnson et al., 2009). Implications and recommendations for future practice include having clear learning outcomes for nursing students in relation to death and dying and providing ample clinical experiences for nurses to practice their skills before entering the workforce (Johnson et al., 2009). Failure to provide support to

students in end-of-life care will continue to create nurses who are stressed and unable to cope with the complexities of care that are involved with dying patients and their families.

5.4 Simulation

When students are not able to have clinical exposure to patients, simulation based learning is a preferred alternative for many medical and nursing schools during this decade. Simulated clinical experience is the primary teaching method used at one Midwestern College in the United States in the undergraduate nursing program (Leighton & Dubas, 2009). Kinesthetic and visual learners may benefit from simulated experiences as they are able to apply the course content in a safe, risk-free environment where they have hands on exposure to a patient simulator (Leighton & Dubas, 2009). It is often very difficult for nursing faculty to place students in clinical experiences where they will encounter end-of-life situations or care for a dying patient. Students may lack understanding and awareness of critical cases and therefore the care of a dying patient may require the expertise of a registered nurse, where students again miss out on opportunity for learning as the primary nurse must step in when the patients condition becomes critical. As a result, simulation labs may serve as a substitute to the clinical environment where students can practice how to care for dying patients and provide care to their families in an environment conducive to learning without risk of saying or doing something inappropriate (Dickinson, 2007; Leighton & Dubas, 2009). Visualizing and providing care on a mannequin provides students the opportunity to apply the content taught within death and dying didactic courses.

The simulated experience example provided in this study included a middle-aged woman with metastatic ovarian cancer who was palliated for comfort care. Students are provided with the patient history and an overview of the scenario to enable students to prepare and research the

patients condition and history, as they would regularly do with their patients in clinical practice (Leighton & Dubas, 2009). They underscore the realism that was created by a simulator mannequin with programmable software that simulated conditions and symptoms with a microphone application allowing the mannequin to speak. In addition, encouraging family members to be a part of the simulated scenarios made the situations even more realistic as students were able to practice how to interact with grieving family members and how to appropriately answer their questions and concerns. Student expectations within these scenarios involved assessing the patient and family, evaluating data, intervening and documenting their care (Leighton & Dubas, 2009). Simulated experiences mimicking real life situations that occur at the bedside are presented as an important learning tool for students.

Student evaluations of the simulated experiences highlight a few common themes. The impact of family presence, realism or fidelity of the simulation, and self-efficacy were the most common responses from students (Leighton & Dubas, 2009). As family care is essential during end-of-life, learning how to communicate information to families and understanding their concerns and questions is fundamental to nursing care. Therefore, having a family member in the simulated experience heightened the realism of the scenario. In this context, students learned how to be present with families, communicate difficult information, and assist them in the grieving process. Moreover, the realistic nature of the experience was a common response from students. One student reported that simulation felt like a real life scenario where she experienced “emotions and feelings” (Leighton & Dubas, 2009, p. 227) while another stated they learned best by “doing things” and they could envision the “whole picture” of the dying process (Leighton & Dubas, 2009, p. 227). Students valued the learning experience as it made them critically think and helped reveal their strengths and weaknesses in caring for dying patients and their families

(Leighton & Dubas, 2009). The simulated experience is a useful teaching method brought about by technology that can be used alternatively to clinical experience. Yet, the fundamental pedagogical principles underlying these learning experiences are similar to the ones outlined in relation to simulation and student-patient contact during the previous decades.

Similarly, Moreland, Lemieux and Myers (2012) portray simulated experiences as an efficient, productive teaching method that supports students as they practice problem solving skills and critical thinking while learning in a safe, less stressful environment with their colleagues (Moreland et al., 2012). Because death and dying encompasses stress and emotions, simulated experiences are seen as an excellent way for students to practice the skills and steps necessary in highly stressful situations so that they are better prepared to deal with real life scenarios with their patients. The authors hypothesize that high-fidelity simulation experiences will increase knowledge and self confidence of undergraduate nursing students in learning and applying end-of-life material to practice (Moreland et al., 2012).

The quasi-experimental study contains a convenience sample of fourteen students who agreed to participate in a fifteen minute simulation involving a terminally ill cancer patient scenario in their nursing laboratory with a human patient simulator (Moreland et al., 2012). The simulation is aimed at showcasing the respiratory, cardiovascular, genitourinary, and cognitive changes that occur as a patient deteriorates and dies. Testing was conducted before, during and after the simulation so that the testers could evaluate student progress. Students are able to recognize the physical and psychological changes that occur with a deteriorating patient as was simulated by the mannequin. Students reflected on their ability to understand the “big picture” with end-of-life care for patients and their families and how their perspectives of care changed from curing to caring (Moreland et al., 2012, p. 12). Simulation is presented as an excellent

alternative for clinical learning as often schools of nursing find it challenging to ensure student clinical placements in palliative care. The gains in knowledge, confidence, self-efficacy and communication skills underscore the benefits of simulation.

5.5 Competencies

Competencies were being used to guide curriculum content for death and dying education in the previous decade. In the 1990s, the use of competencies was mainly seen in scholarly literature from medical journals. In the 21st century, there was a shift in the explicit use of competencies to guide student learning in both nursing and medical disciplines. A transition is seen in this time period as frequent reference is made to the End of Life Nursing Education Consortium (ELNEC) education program which is a new resource used to provide basic end-of-life knowledge for students to be able to competently care for dying patients (Paice, Ferrell, Virani, Grant, Malloy, & Rhome, 2006; Thompson, 2005; Todoro-Franceschi, 2011; Wallace, Grossman, Campbell, Robert, Lange, & Shea, 2008; Weissman, 2011). The emergence of the ELNEC demonstrates how more explicit attention is given to end-of-life care education during this decade.

The ELNEC education program is one solution to ensuring that undergraduate nursing students in the United States all receive education on the same content (Paice et al., 2006). Furthermore, the purpose of this educational program is to ensure that patients receive the best quality care at the last stages of their life with nine key areas identified as core competencies for nursing students to learn and understand (Paice et al., 2006; Todaro-Franceschi, 2011). The modules of core competencies include pain management, symptom management, cultural considerations, ethical and legal issues, communication, loss, grief, and bereavement, preparing for care at the time of death, and providing quality end-of-life care (Paice et al., 2006; ;

Thompson, 2005; Todaro-Franceschi, 2011). These areas have been identified as the minimal education and training needed to provide end-of-life care to patients and their families. The modules used in the ELNEC program reflect on the core competencies and are taught through didactic and experiential training methods including slides, CD-ROM, video clips, case studies, and role-play sessions (Paice et al., 2006). Thompson (2005) suggests that guest speakers from hospice services could enlighten students on their personal experiences in managing grief and loss experienced by patients and their families. Guest speakers could invite new perspectives to death and dying education and propose new ways of thinking about death concepts. The different teaching strategies were used on different class days to ensure that students were engaged with new teaching methods to meet a variety of learning needs (Paice et al., 2006).

Nursing students reported that the ELNEC modules and teaching strategies provided them with sufficient training to feel confident in caring for patients who are dying. The main areas where nursing students benefited included education on symptom management and communication tools when speaking with the patient or their loved ones about expected outcomes (Paice et al., 2006). Communication is one of the most fundamental skills for all nurses and an entire module is dedicated to recommendations on how to best communicate with patients and families. The nurse-patient relationship is established based on clear communication, truth telling, and active listening (Weissman, 2011). Communication, especially at the end-of-life and during death related situations is crucial and often challenging due to the death adverse culture. The ELNEC guidelines are used by nurse educators as the learning outcomes for essential end-of-life education that needs to be given to nursing students. As a result, it may be indicated that active learning approaches such as clinical experience and role playing may help engage students

better and facilitate self-efficacy from practicing their techniques in a health care setting (Weissman, 2011).

The ELNEC program was also integrated into an undergraduate-nursing curriculum, as most nursing programs do not have a dedicated course on death (Wallace et al., 2008). The literature from this study supports the use of various innovative teaching and learning strategies to make the important information on symptom management and communication tools resonate with students. The ELNEC program was integrated into existing courses within the nursing curriculum with faculty teaching these courses that had been previously given instruction and training on ELNEC modules. Interestingly, this approach includes attention to the fact that the teachers also need to be instructed and supported on the provision of death education. This concept is rarely discussed in the literature examined in this study thus far.

The integration of the nine modules begins in the first semester where sophomore students are educated on the importance of communication (module 6) in their professional nursing course and introduced to palliative care (module 1) and ethics of palliative care (module 4) in their health care delivery system course (Wallace et al., 2008). In the second semester, students focus on geriatric care where death (module 9) and pain and symptom management (module 2) are incorporated into their wellness and illness course (Wallace et al., 2008). The mental health covers the remaining modules including loss, grief, and bereavement (module 7). The integration of modules within existing courses makes teaching this vital information easier for faculty who are not forced to create new learning tools but can include the new information within existing course content. This integration is also advantageous to curriculum designers who do not need to make major alterations to include additional death courses for their students.

Students are graded based on assignments that consisted of self-reflections, critical review of an article, weekly class participation, and an online discussion board used to share their clinical experiences (Todaro-Franceschi, 2011). The ELNEC competencies are used as a guideline to student educational topics and also as a reference for grading purposes to ensure students are meeting all competencies necessary to pass the course. The student feedback regarding their increase in confidence further support the use of ELNEC modules as a foundation for death education and preparing students for death related situations.

Death and dying competencies were similarly revealed in a critical review of nursing textbooks (Kirchhoff, Beckstrand, & Anumandla, 2003). According to these authors, textbooks are an essential source for students to become aware of guidelines and practice standards. This analysis is useful in determining how death education has been addressed. The American Association of Colleges of Nursing (AACN) identifies explicit end-of-life competencies for undergraduate nursing curriculum and these are used as a guideline for textbook analysis to ensure that the textbooks included information about each of the fifteen essential competencies listed below. These nursing competencies are considered essential for the National Council Licensure Examination for Registered Nurses (NCLEX-RN) (Kirchhoff et al., 2003).

Table 5.2 AACN End-of-life competencies for undergraduate nursing curriculum (as cited in Kirchhoff et al., 2003, p.373).

1. Recognize dynamic changes in population demographics, health care economics, and services delivery that necessitate improved professional preparation for end-of-life care.
2. Promote the provision of comfort care to the dying as an active, desirable, and important skill, and an integral component of nursing care.
3. Communicate effectively and compassionately with the patient, family, and health care team members about end-of-life issues.
4. Recognize ones own attitudes, feelings, values and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs.
5. Demonstrate respect for the patient’s views and wishes during end-of-life care.

6. Collaborate with interdisciplinary team members while implementing the nursing role in end-of-life care.
7. Use scientifically based standardized tools to assess symptoms (eg. Pain, dyspnea, constipation, anxiety, fatigue, nausea/vomiting, and altered cognition) experiences by patients at the end-of-life.
8. Use data from symptom assessment to plan and intervene in symptom management using state-of-the-art traditional and complimentary approaches.
9. Evaluate the impact of traditional, complementary, and technological therapies on patient-centered outcomes.
10. Assess and treat multiple dimensions, including physical, psychological, social, and spiritual needs, to improve quality at end-of-life.
11. Assist the patient, family, colleagues, and oneself to cope with suffering, grief, loss, and bereavement in end-of-life care.
12. Apply legal and ethical principles in the analysis of complex issues in end-of-life care, recognizing the influence of personal values, professional codes, and patient preferences.
13. Identify barriers and facilitators to patients and caregivers effective use of resources.
14. Demonstrate skill and implementing a plan for improved end-of-life care within a dynamic and complex health care delivery system.
15. Apply knowledge gained from palliative care research to end-of-life education and care.

Upon reflection and review of critical care textbooks, the following areas were reviewed and assessed for inclusiveness based on the AACN competencies listed above: assessments, pharmacology, psychiatric-mental health, nursing management courses, ethical/legal issues, cultural issues, and professional issues (Kirchhoff et al., 2003). The critical care textbooks evaluated in this study however, made no mention on how to conduct assessments on patients nearing death (Kirchhoff et al., 2003). One of the core responsibilities of nurses is to provide comfort care and ensure that patients are pain free and yet, pharmacology is minimally discussed but promoting patient comfort is viewed as essential for nursing care (Kirchhoff et al., 2003). Providing psychological care for patients and families is also a key aspect of providing holistic care to patients nearing death. In the nursing textbooks evaluated, Kirchhoff et al., (2003) review the importance of clear communication and providing care in an open, compassionate and caring

method while discussions about family wishes including cultural and spiritual care are brought into focus.

Recommendations from this review of critical care nursing textbooks strongly indicate the need for in-depth inclusion of end-of-life competencies. Nurses rely heavily on textbooks for support during their undergraduate years as well as when practicing as a registered nurse for guidance and support. In particular, areas that need comprehensive inclusion include pharmacology and the importance of pain management with emphasis on medicinal choices, symptom-specific medications and their side effects in order for nurses to provide adequate pain management (Kirchhoff et al., 2003). In addition, learning how to communicate effectively with patients and families is another key aspect to nursing care that requires further inclusion in nursing textbooks. Nurses spend a large amount of time with patients and develop rapport in their trusting relationships. Textbooks must be inclusive of how to communicate effectively with patients and families and incorporate the principles used when delivering difficult information to loved ones (Kirchhoff et al., 2003). These improvements to nursing textbooks will help improve the deficiencies in nursing textbooks and positively impact the course content on death and dying that is taught to nursing students.

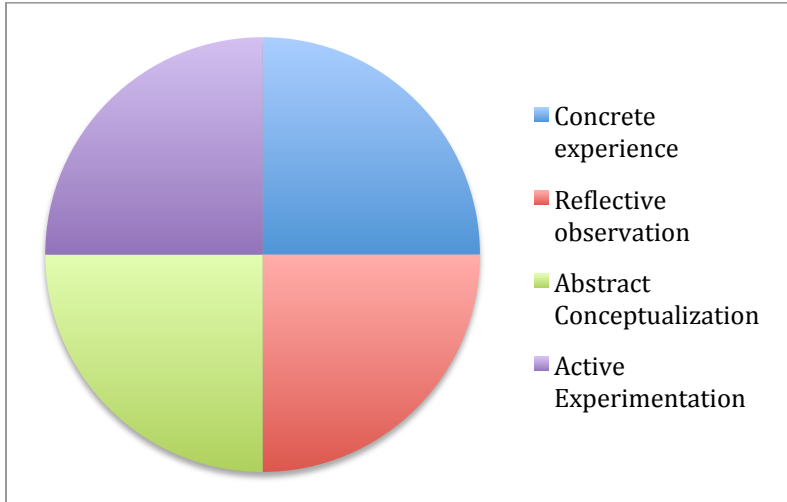
The ELNEC competencies and recommendations from the critical nursing textbook review suggest the need for end-of-life competencies for all nursing and medical curricula (Paice et al., 2006; Thompson, 2005; Todoro-Franceschi, 2011; Wallace et al., 2008; Weissman, 2011). The key concepts explored through the modules include symptom management, communication tools, and understanding the grieving process, which are all key elements to providing holistic care to patients and families at the end-of-life.

5.6 Online learning

A new emphasis on using technology brings forward advanced methods to teach death and dying through distance learning. Online learning is a new focus during this time period and not previously discussed in the earlier literature. Death and dying education taught through an online course promote new ways of teaching and learning for both educators and students.

A blended course on death and dying is recommended by Kavanaugh et al. (2009) as a combination of classroom work and online learning to provide health care professionals with the content associated with death and dying. Evaluation of the blended course reveals that students gain a great deal of knowledge from the interactive learning experiences through the online portion of the course as various teaching methods are used to meet a variety of learning styles (Kavanaugh et al., 2009). Having face-to-face classes incorporated within the course would give students opportunities to build connections with classmates and their instructors, which can be more challenging through an online course. Using Kolb's experiential learning theory as the framework for the course, four online learning modules are developed which included concrete experience, reflective observation, abstract conceptualization, and active experimentation (Kavanaugh et al., 2009).

Table 5.3 Kolb's experiential learning theory (Kavanugh et al., 2009, p. 127)



The learning circle begins with a concrete experience that encompasses a human experience consisting of viewing a video or listening to an audio clip in which students hear and see patients talk about their experiences. Furthermore, students engage with dying patients, which creates humanizing experiences that offer more learning than reading from a textbook. Hearing the personal experiences of patients and families expressing their fears, anxieties and insights created more realistic experiences for student learning. Students then progress to the reflective observation stage of learning in which they reflect on the video or scenario examined during the concrete experience phase and by answering short questions. In the third phase of abstract conceptualization, students consider theoretical concepts through video clips, power points and case studies. The abstract portion of the course is crucial in identifying theories on death, dying, and loss as they impact the care students provide their patients. The last portion of the learning circle involves active experimentation through which students apply the knowledge in online group discussions forums where they learn from the viewpoints of their classmates. The blended learning program includes the online course and also three face-to-face classes to explore the more sensitive topics surrounding death (Kavanaugh et al., 2009). Speaking with

classmates and instructors through online discussion boards was found to be an excellent way for students to share their learning experiences and learn from others.

Similarly, Todaro-Franceschi (2011) discusses the advantages of online learning for students. In a New York University, the nursing curriculum is investigated for their inclusion of death concepts. This particular university uses an online Blackboard system as a method for students and teachers to communicate about topics out of the classroom. Using this technology, instructors are able to engage with students from a distance and continue to discuss topics from the readings for that week. This approach creates a course with ongoing teaching and learning where students can share their personal experiences from their practicums and clinical placements (Todaro-Franceschi, 2011).

The use of Blackboard online teaching is unique to this school of nursing as teachers benefit from being able to connect with students from home and engage in their group discussions. Nurses feel more prepared and confident to care for dying patients and help their families with the grieving process (Todaro-Franceschi, 2011). Overall, speaking with classmates online through Blackboard on their personal clinical experiences helps students learn from each other's experiences and gain understanding about the specialized needs of patients and families at the end-of-life.

5.7 Care of the dead body

Care of the dead body has been a recurrent theme across each decade analyzed in this study. The nursing enactments involved in the care of a deceased patient have been highlighted in both textbooks and scholarly literature since the 1970s, suggesting that it should be considered as important component of death education. Physical care of the dead body is given explicit attention during this decade.

Nurses have an important role in caring for the dead body. Blum (2006) describes the steps nurses must take when a patient dies, including contacting the most responsible physician, family comfort care, and preparing the dead body. Providing privacy, respect and preserving dignity are the key elements to providing the best end-of-life care (Blum, 2006). Providing families time to grieve and view the body is essential. Often there are rituals or special cultural practices that families may want to incorporate. It is essential for health care providers to be knowledgeable and open to these cultural practices. Knowing the hospital policies on end-of-life care is essential before beginning to care for a deceased body.

Cleaning the body is an important aspect to care for the dead. Changing dressings, removing tubes and drains, and closing the eyes and mouth if appropriate are recommended when preparing the body for transfer to the morgue (Blum, 2006). Nurses must focus on the patient but also care for the grieving families. Cleaning the environment and ensuring tidiness is key to creating a nice open environment for families and suggests a peaceful death while the nurse comforts loved ones who visit (Blum, 2006). After the body has been cleaned, families should be given another opportunity to say goodbye to their loved one. Before transferring the patient, nurses must document and remove any personal belongings of the patient (Blum, 2006). The body should be treated carefully so that no damage occurs.

Hadders' (2007) work emphasizes the role of critical care nurses in the intensive care unit (ICU). He reviews the results of semi-structures interviews from twenty-seven ICU nurses at the Trondheim University Hospital in Norway. Hadders (2007) explores the enactments of nursing staff and highlights how nurses deal with the dead patient in the ICU setting. Nurses are responsible for the last offices and preparing the body for viewing for family. In this context, it is

the nurse's utmost responsibility to preserve the integrity of the human body by washing, dressing and removing any tubes from the body (Hadders, 2007).

In the interviews, the nurses describe the importance of moving the patient to a private room to provide respect for the dying patient and their family. The steps of washing a patient are described in detail by handling the body with care when turning, closing the eyes, jaw and mouth, removing all soiled dressings, bloody linens and any tubes from the patients body (Hadders, 2007). Some nurses reflect on the importance of talking to the patient by informing them of what they are doing next as important in their practice. This idea stems from the belief that comatose patients still can hear what is going on around them so this aids nurses in maintaining a relationship with the patient (Hadders, 2007).

The distancing of a nurse from a dead patient is an interesting idea presented by one of the nurses in the study. The distance between the nurse and a dead patient is affected by the social status of that particular patient. She states that it was more difficult to care for a dead body when the patient affected the "ontological security" of the nurse by being close in age, gender, or social position (Hadders, 2007, p. 219). Safeguarding the integrity of the human body in all acts of care is integral to end-of-life care (Hadders, 2007). It may be more difficult for a nurse to care for a dead person who they can relate to in age and gender. This may also contribute to increased anxiety, fear and avoidance behaviours. Deceased patients should be treated with the same care and compassion as living patients.

Hadders (2009) describes the enactments of death using Mol's praxiographic approach to present how death is done or enacted within the ICU. The author focuses on two dimensions of death enactment; on one hand he explored the procedure manual from the Trondheim University Hospital and on the other hand, he examined medical practice. He observes a gap between

institutional demands through procedure manuals and the nurses' individual practices of caring for the deceased. There may be a discrepancy between what is recommended by the textual discourses and what actually occurs in reality when caring for the deceased due to institutional demands that nurses face. The newly revised procedural manual highlights this discrepancy. While there are some mandatory post-mortem care aspects such as respecting patient integrity and preparing the body for viewing, there are also some aspects to care that should be personalized to the family and cultural rituals (Hadders, 2009). The institutional demands and environment impact how nurses do their work. Time constraints, lack of experience, and ward culture may impact the manner in which care is completed. While it may be recommended to follow the procedure manual, nurses work in the moment responding to patient needs and may be impacted by the manner in which colleagues or the unit culture conducts care at the end-of-life.

In both articles, Hadders describes the steps of washing the deceased body, highlighting the importance of respecting the deceased body when performing the last offices. Subtle changes in norms and meaning in care of the dead body are enacted, such as placing nametags on the wrist instead of the toe as an indication of the increased attention to personalized approaches as compared to previous decades (Hadders, 2009).

Hadders (2009) reviews the multiple enactments of death in the ICU through the various medical technologies and ontologies of death. He explains that new advancements in technology including mechanical ventilation and cardiac monitoring have become the standard for monitoring a client's condition and thus become the main context of death in this environment (Hadders, 2009). While traditional methods of pronouncing a death included nurses and physicians watching the patient for signs of activity and listening to the heart activity with a stethoscope, new monitoring devices have replaced these methods and hence have changed

practice. Using technology to monitor signs of death, for example, underscores the separation nurses and health care professionals may have with death.

Terminal weaning and terminal extubation treatments are common enactments of death within the ICU that make real the impending death of the patient. The withdrawal of ventilator treatment involves a slow procedure in which ventilator support is decreased in steps (Hadders, 2009). Furthermore, families also rely on the cardiac monitor for signs of death as they anticipate the flat electrocardiogram (ECG) line as an enactment of death (Hadders, 2009). It is common practice for nurses to turn off the monitor screen at the bedside so that families can be present with their loved one and focus their attention on the dying patient versus being disturbed by the changes on the cardiac monitor. The physician pronouncement of death is another enactment of death within the ICU that makes the situation real, often by auscultating for heart and breath sounds with a stethoscope (Hadders, 2009). As technology changes, death practices also change.

Caring for patients after death is an important aspect to end-of-life care. Nurses' practical training in hands-on tasks of caring for a dead body requires careful consideration as this may cause anxiety and uneasiness. Preparing a body for viewing often involves cultural practices and is influenced by family wishes (Pattison, 2008). For example, when washing the patient's body, it is crucial for nurses to be aware of the previous wishes of the patient or rituals that may be important to the religious faith of the family. Removing jewelry or personal belongings from the deceased is common practice for nurses. It is important to consider the sensitive nature of removing jewelry or clothing, as nurses should incorporate the family's wishes in this process (Pattison, 2008).

Preparing family members on what to expect when viewing the deceased patient is an important aspect of care. Nurses should provide families with information on what they may

expect to see, accompany family members but respect their space and privacy, and provide information on bereavement services (Pattison, 2008). Bereaved family members may rely heavily on nursing staff to answer their questions and concerns about the next stages in managing the body as well as funeral arrangements. The grieving process is accompanied by emotion, disbelief, shock, avoidance and sadness. Nurses need to be prepared to manage varying reactions from loved ones including physical changes such as syncope, chest pain hyperventilation and vomiting when family members encounter the deceased (Pattison, 2008). Nurses may also be affected personally by the death so must remember to acknowledge their emotions and collaborate with the health care team to meet family needs.

The final preparation of the dead body includes the nurse placing the body in a bag before transporting the deceased to the morgue. Grief is experienced by both family members and health care professionals involved, therefore, preparing the body can help aid nurses in achieving closure on the patient's death (Pattison, 2008). The manner in which nurses enact death requires careful consideration and should be performed in a holistic manner respecting patient and family wishes. During this decade, a renewed and explicit interest in caring for the dead body emerged. This idea is brought about by a changing context of care, particularly influenced by technological advancements. Changing norms about providing personalized care are a result of these changes within the health care environment.

5.8 Teamwork

Multidisciplinary approaches to patient care at the end-of-life become more prominent in this decade. Teamwork is found to be essential to meet patient and family needs due to complex patient conditions as well as difficulties associated with supporting families during the stressful times of death. Literature suggests that in order for health care professionals to understand the

roles and responsibilities of one another, they must also be educated on the death and dying concepts in a team setting.

Cavaye and Watts (2010) stress that good quality care for dying patients is a priority in the United Kingdom which is being echoed in pre-registration nursing curricula. Nurses provide immediate care to dying patients, provide comfort care and aim to meet both patient and family centered needs but must involve the interdisciplinary team to provide holistic care. Cognitive, affective and psychomotor elements are described as the foundations to learning about death and dying (Cavaye & Watts, 2010). This includes critical thinking, self-questioning and hands on enactments of caring for a dying patient (Cavaye & Watts, 2010). In addition, learning how to effectively communicate with patients and families is a key part of providing quality end-of-life care. Specifically, learning how to communicate patient specific information and facilitating dialogue with patients and families should be an essential component in death education courses (Cavaye & Watts, 2010). Learning how to communicate difficult information to patients and families and how to be empathetic and truthful is an important skill to learn as a student.

The shortcomings of providing adequate end-of-life care to patients is not solely due to insufficient education of nursing students but also due to the environment, organizational constraints, and lack of resources within the health care setting to support staff (Cavaye & Watts, 2010). End-of-life care involves a team of health care professionals within a demanding health care system with various patient specific needs. Teamwork is essential during difficult end-of-life situations as well as to support patients and families with their wishes. Each member of the health care team offers different perspectives and may have specific areas of expertise that can impact patient care (Cavaye & Watts, 2010). Therefore, it is imperative for health care professionals to work collaboratively to provide the best quality care.

An interdisciplinary education program is described as an effective method to promote collaboration and teamwork amongst health care professionals in complex clinical areas such as palliative care (Fineberg, Wenger, & Forrow, 2004). Fineberg et al., (2004) reiterate the benefits of interdisciplinary education courses as professionals learn about mutual respect, communication, trust, and develop a team identity which may lead to fewer role conflicts in the health care environment. This creates cohesiveness and helps with team building and collaborative practice in the health care setting.

In the palliative care setting, multidisciplinary approaches are recommended to meet patient and family needs and should be the standard of practice. Therefore, educating social work and medical students together prepares them to work in a team-orientated environment upon graduation. Learning about the roles, responsibilities and viewpoints of other professionals encourages students to gain acceptance for opposing views and build trusting relationships with their colleagues (Fineberg et al., 2004). This study suggests that interdisciplinary palliative and death education programs are currently being developed and more research is needed on the effectiveness of interdisciplinary death education.

5.9 Educators

Various scholarly articles have mentioned the lack of educators wanting to teach students about death. Hardly any explicit literature, however, considers how to best support educators so they feel more confident teaching these topics. This problem remains consistent across each decade analyzed in this study and limited information or recommendations are offered to support faculty.

Mallory (2003) includes discussion of the lack of confidence among educators as one of the reasons death education is limited. She reflects on the historical issues of limited clinical

experiences and didactic education on death and dying. This problem stems from an already overcrowded curriculum, lack of confidence from teachers to teach these difficult topics, and an overwhelming fear of death by society as a whole (Mallory, 2003). Yet, the intervention study he undertook focuses again on the students learning and perspectives. The intervention group received death education courses and was given clinical experiences in palliative care while the control group did not receive these interventions (Mallory, 2003).

Students in the intervention group are given both didactic lessons on death and the dying process as well as experiential learning opportunities. The students participate in role play activities and engaged in group discussions, spent a clinical day on a hospice unit observing the role of the nurse and viewed an anatomy cadaver laboratory to learn about post mortem care and burial services (Mallory, 2003). The results of the post test reveal that students in the intervention group who had experiential learning opportunities benefit from these experiences as they develop positive attitudes towards the dying process and are better able to provide quality care to their patients and families. Yet, the role of the educator remains underexplored in this study.

The perspectives on death education presented by Wass (2010) are a striking example of the many ways we are surrounded by a death-adverse society. Particularly, the language of death itself is often replaced with new words such as end-of-life, hospice, palliative or terminal (Wass, 2010). This avoidance of death language stems from the fear of death and a lack of understanding of what death represents. This impacts the manner in which educators are set up to teach these difficult topics.

The literature over the last forty years speaks to the need for improvements in death education in nursing and medical curricula (Wass, 2010). Wass (2010) highlights the changes

that have occurred including the hospice movement, which focuses on the care of people at the last stages of their life. The hospice programs are alternatives to the traditional “curing” but focus more so on “caring” and “comfort”.

Wass (2010) suggests that a lecture here or there on death and end-of-life care is not sufficient, considering how often health care professional must encounter death. The complexities of end-of-life care invite nursing and medical curricula to create more structured courses or integrate concepts within their existing programs. Instructors report that insufficient time and lack of faculty resources to teach these topics are the main reasons why death education importance is not stressed within the curriculum (Johnson, Chang, & O’Brien, 2009; Wass, 2010). More attention must be given to support instructors so that they have the necessary tools and training to confidently teach death related topics.

5.10 Textbooks

In a Canadian Fundamentals of Nursing textbook, one chapter titled “*the experience of loss, death, and grief*” covers death related topics in depth (Potter & Perry, 2006). The chapter focuses both on patient care and family care. The topics of grief and bereavement are explored at length with the inclusion of various grief process theories (Potter & Perry, 2006).

The authors describe different methods to provide comfort care to the terminally ill patient. Treating nausea, dehydration, shortness of breath, and incontinence are some examples of symptoms that patients nearing death may experience that require immediate nursing attention (Potter & Perry, 2006). This text suggests that non-pharmacological and pharmacological options should both be explored to provide comfort to patients. Moreover, post-mortem care is also described in a step-by-step manner highlighting the essentials of preserving dignity and respecting client and family wishes (Potter & Perry, 2006). Nurses have a key responsibility with

patients and families. They create a caring presence by using therapeutic communication and respecting personal wishes.

In a Critical Care Nursing textbook from 2005, the authors dedicate a chapter titled “*the family’s experience with critical illness*” to topics related to end-of-life and death. Morton, Fontaine, Hudak and Gallo (2005), describe coping mechanisms, nursing interventions at the end-of-life, cultural issues, and steps to take after a patient’s death. The importance of having frequent communication with families is emphasized as patient conditions can quickly change and using simple language to describe the patient’s state is necessary.

The steps taken after a death occurs are briefly mentioned as the nurse must fill out the appropriate paper work with families and provide emotional support as needed (Morton et al., 2005). Interestingly, no mention is made of the steps and procedures needing to take place with the dead body, whereas some of the scholarly literature during this decade does focus on this aspect. Perhaps this indicates that textbook knowledge typically reflects a slight time gap in incorporating latest research findings. It seems this topic gained renewed interest after having been overlooked during the decades that much emphasis was place on psychosocial care. However, the concept of dead body care was described in detail in the textbooks included in the first decade covered by this study.

5.11 Discussion

Various themes are illuminated in the analysis of literature and textbooks from 2000 – onwards. These themes related to an increase in literature surrounding nursing enactments with the dead body, recommendations for experiential learning as the best method to teach death and dying topics and the use of a collaborative approach to providing care to grieving families (Birkholz et al., 2004; Blum, 2006; Dickinson, 2007; Fineberg, Wenger et al., 2004; Hadders,

2007; Hadders, 2009, Johnson et al., 2009; Leighton & Dubas, 2009; Moreland et al., 2012; Paice et al., 2006; Pattison, 2008). One new teaching method not previously explored is that of online learning methods to teach the topics of death and dying (Kavanaugh et al., 2009; Todaro-Franceschi, 2011).

Several journal articles highlighted the steps and importance of washing the dead body. This concept has been reiterated throughout each decade analyzed in this study but receives particular attention again in the most recent time period. Encompassing cultural practices of the patient and family, preserving dignity, and tidying the room to prepare for viewing of the dead body are key responsibilities of the nurse who is caring for the deceased patient (Blum, 2006; Hadders, 2007; Hadders, 2009; Pattison, 2008). The enactments of a nurse during the care at the end-of-life may involve specific rituals and should be considerate of personal wishes of the family. Learning the physical care that a nurse provides is fundamental for nursing curricula to include as this is often the source of stress and anxiety for many health care professionals. As many students learn best through applying the skills into practice, experiential learning methods are suggested.

Experiential learning appears to be the most recommended method to teaching topics related to death and dying. While didactic learning approaches such as PowerPoint's and reading literature can be helpful to understand the concepts surrounding the dying process, various studies emphasize that it is imperative for students to engage with dying patients, shadow a hospice nurse or take part in supervised clinical experiences so they have direct patient and family contact (Birkholz et al., 2004; Johnson et al., 2009). As students can learn about the patients experience through face-to-face interactions, perhaps the best environment to learning would be clinical placements in palliative care or hospice settings. Due to limited clinical

placements, however, clinical experiences are not always possible. As a result, simulation based learning is a recommended alternative method to teach end-of-life skills to nurses in a safe environment with a simulator doll that can replicate the symptoms and problems a real patient may experience when nearing death (Leighton & Dubas, 2009; Mallory, 2003; Moreland et al., 2012). Students learn how to problem solve, critically think, and practice the skills necessary in highly stressful situations in a less stressful environment with the help of their colleagues (Moreland et al., 2012). Simulation based learning can increase self-efficacy and better prepare nurses to manage these situations in real life when patient care is at stake. Nurses spend a great deal of time with patients and families at the end-of-life but care must also involve members of the health care team to provide the best quality care to patients.

Collaborative end-of-life care is recommended as best practice in the literature reviewed. Patients and families are experiencing loss, denial and grief and have various needs that need to be addressed by all health care professionals involved. As a result, including all members of the health care team will help provide holistic care so that family wishes are respected and incorporated into patient care (Fineberg et al., 2004). Specifically, students can benefit from learning about death and dying topics from professionals of different disciplines as this prepares them to work in a team-oriented environment with knowledge about the roles and responsibilities of their colleagues who they will closely work with (Fineberg et al., 2004; Hadders, 2007; Thompson, 2005). Fineberg et al. (2004) highlight the advantages of interdisciplinary palliative and death education programs where multi-disciplinary team learning together will urge health care professionals to learn about the importance of collaboration and build trusting relationships with other professionals, leading to improved patient outcomes. Teamwork, they argue, meets the growing demands of patients and families in a rapidly changing health care setting. In

addition, team training and multidisciplinary classroom learning can help students from different disciplines learn about the roles and responsibilities of their future colleagues. Educating students of various health care disciplines together is one way to promote collaboration and enhance team building.

Articulation of death and dying educational competencies were a major influence during the 21st century. Competencies were implemented in nursing and medical curricula in efforts to improve patient outcomes by offering consistency in professional knowledge and performance (Nelson & Purkis, 2004). The End of Life Nursing Education Consortium (ELNEC) guidelines are introduced in various nursing curricula as a foundation to death and dying education. The course concepts of the ELNEC program elaborate on the essential end-of-life knowledge that every nursing student should be educated about before entering practice. These include instruction on death, cultural and religious practices, palliative care, pain and symptom management, ethical and legal issues, final hours before death, communication, grief and care after death (Paice et al., 2006; Thompson, 2005; Todoro-Franceschi, 2011; Wallace et al., 2008; Weissman, 2011). Most schools provide education on these modules within an integrative classroom format. However, online learning is introduced in this decade as a beneficial method for students to engage with interactive learning on death related subjects. Students have weekly discussion on their online discussion board in which they participate in group discussions and share clinical experiences with their colleagues (Kavanaugh et al., 2009; Todoro-Franceschi, 2011). Online learning may also help students speak more openly about their personal feelings and ask questions as they are communicating online rather than speaking in person in a classroom. With increasing use of technology, online learning is now becoming a more common method used in various health disciplines. Online learning offers additional educational options,

which impacts both students and educators.

The grieving process and theories surrounding loss are foregrounded in this decade. Although the emergence of loss and grief concepts are initially seen in the literature from the 1990s, there is specific attention given to assisting patients and families with the grieving process in this time period. Notably, the literature reflecting the ELNEC competencies all include a module on grief, loss or bereavement principles (Kirchhoff et al., 2003; Paice et al., 2006; Thompson, 2005; Todaro- Franceschi, 2011; Wallace et al., 2008). In addition, grief and loss was reported by several authors as the most covered theoretical content in relation to death education (Dickinson, 2007; Johnson et al., 2009; Pattison, 2008). Educating students on these principles is considered one of the vital competencies to prepare nursing students for graduation. In addition, the grieving process affects many stakeholders including patients, families, the primary nurse and all other members of the health care team. In this capacity, it was important for all parties involved to understand the stages of grieving and be aware of support systems available (Johnson et al., 2009; Kirchhoff et al., 2003; Potter & Perry, 2006).

In the nursing fundamentals textbook explored for this decade, an entire chapter is dedicated to concepts related to loss, death and grief (Potter & Perry, 2006). This is a significant expansion from all of the previous textbooks analyzed as the authors highlight various grief process theories, among others, referencing the seminal work of Kubler- Ross's theory on grieving as the most commonly used in Canadian nursing programs (Potter & Perry, 2006). This new conceptualization of grief and loss may in part be due to increased attention to patient and family centered care. During this decade, more attention is given to considering family wishes and ensuring that both patients and their families are supported through the death and dying

experience. The final chapter of this study will review the overarching themes across each of the decades analyzed.

CHAPTER 6: Conclusions and Recommendations

The main question that I sought to answer in this study was to examine how death education was enacted over the time period from the 1970s onwards according to nursing and medical scholarly journals and nursing textbooks. In addition, I aimed to identify how the cultural norms of death influence how educators are positioned to teach death related topics. In this context, I identified the most common recommendations from the literature as to the best methods to teach students on death and dying concepts and practices so they can provide the most appropriate client-centered care to their patients and families. A decade-by-decade approach was followed in reviewing relevant literature on death education. The lens of performance theory was used to understand how death is enacted over time.

During the 1970s, death education was enacted with the patient as a primary teacher for students (Barton et al., 1972; Bloch, 1976; Liston, 1973; Synder et al., 1973). Those who sought to renew curricula on death education argued that dying patients could provide a great deal of insight about the fears and emotions associated with dying. Psychosocial care was considered the most important aspect of death and dying care. Identifying emotions, fears and feelings in relation to the death experience was stressed as the the core of nursing care, moving away from an earlier time period in which only physical care of the dead body seemed to be emphasized. Increasingly, considerations of the family's spiritual and cultural practices were seen as importance factors to be included in death education (Stefan & College, 1978). The focus on psychosocial aspects of care could in part be due to more one-on-one contact with patients and families and less technology present to distract nurses from communicating with patients, a concept that is later explored and seen by some as problematic for patient-nurse interactions (Hadders, 2009). The principles of psychosocial care are further explored in the 1980s.

Experiential learning through patient contact is the primary way in which death is enacted in the 1980s. However, in this decade, health care professionals are identified as the most appropriate teachers for students, instead of patients themselves as presumably professionals offer students insights into their roles and experiences in caring for dying patients (Perez et al., 1980). Patient contact in the clinical setting was still a persistent theme. It was found to be necessary for students to engage with dying patients and become exposed to the health care environment (Degner & Gow, 1988a; Degner & Gow, 1988b; Smith et al., 1980).

During the 1990s, death education was enacted primarily through the use of competencies and through integration of death education in existing courses in the curriculum (Barnard et al., 1999; Downe-Wambolt & Tamlyn, 1997; Hill & Stillion, 1995). There is more emphasis on the grieving process and the concept of loss during this time period. Explicit attention is given to students who had previous experiences with death and loss (Downe-Wambolt & Tamlyn, 1997; Hurtig & Stewin, 1990; Potter & Perry, 1997). This idea of the psychosocial needs of patients and families is central to the theories of grief and loss.

In the final chapter, literature from 2000 – 2014 was analyzed. The literature on death education also has grown exponentially during this time period. Death education is enacted through experiential learning methods including patient contact and simulation while integration of courses continues to be emphasized (Birkholz et al., 2004; Johnson et al., 2009; Moreland et al., 2012). Nurse-patient interactions are again seen as the most ideal way for students to learn about the patient's experience with dying. However, since there are limited number of clinical placements available, simulation is another method used to practice problem solving, critical thinking and communicating with patients and families using simulated scenarios (Leighton & Dubas, 2009; Moreland et al., 2012). Death education was also enacted using a collaborative

approach where all members of the health care team had specific responsibilities in responding to the patient and family centered needs (Fineberg et al., 2004).

The inclusion of competencies within nursing literature is a major shift during this time. The End of Life Nursing Education Consortium (ELNEC) guidelines provide recommendations about which core concepts of death and dying education every student needs to be competent with before caring for dying patients (Paice et al., 2006; Thompson, 2005; Todoro-Franceschi, 2011; Weissman, 2011). Moreover, the theories surrounding grief and loss are discussed with emphasis on the psychosocial care needed by patients and their families (Dickinson, 2007; Johnson et al., 2009; Potter & Perry, 2006).

6.1 Themes

This integrative literature review underscores the various ways in which death was enacted from the 1970 – present time. The persistent themes across the decades indicate topics of importance and ones that should be addressed in death and dying education. There are three overarching themes that are first seen in the 1970s and then appear throughout the literature until the 21st century. These themes include the avoidance of death, importance of psychosocial care, and the lack of support for educators.

6.1.1 Avoidance of death

The avoidance of death in the culture at large is a persistent theme in this study. In the 1970s, death concepts were primarily seen in medical and psychiatric journals. Very little information related to death was found in nursing scholarly journals until the 1990s. Death was considered as a failure for practitioners who were in a cure-focused profession where their primary role was to save lives and prolong life (Mermann et al., 1991; Perez et al., 1980). The avoidance of death from health care professionals stemmed from a lack of confidence in dealing

with the complexities involved in end-of-life care as well as anxiety related to the unknowns about the dying process due to a lack of practical experience (Perez et al., 1980).

Furthermore, the actions and language used to describe the dying process was another aspect that reflected to the avoidance of death. Specifically, death was often masked in efforts to hide the true realities of a dead person. For example, a textbook analysis from the 1980s revealed that a corpse was made to appear more life-like as a means to protect family and loved ones (Roach, 1987). In addition, language reflected circumscribed ways of referring to death. Patients no longer died, for example, but “arrested” and the word “dying” was often replaced with words such as end-of-life, hospice, palliative or terminal (Roach, 1987; Wass, 2010). The choice of words used to describe death further supported the fears and unknowns associated with dying. Hadders (2009) explored how technology in the health care environment also impacted the manner in which death was enacted within the intensive care unit (ICU). More emphasis was placed on monitoring the clients’ condition through technology including mechanical ventilation and cardiac monitoring. Instead of the traditional ways of watching for signs of death, health care professionals now rely heavily on new technology as a confirmation of a patient’s death. What may be lost are the psychosocial aspects of caring for patients such as being present with them and being available to have difficult conversations with them about death and dying. Fleming and Brown (1983) echoed this idea as they discussed the issues of nursing curricula focusing on the technology of death instead of the psychology of death. Students are taught how to monitor equipment and new technologies while less focus is given to the psychosocial aspects of death and dying (Fleming & Brown, 1983). The everyday skills and tasks that a nurse enacts appear to have more importance than the supportive role that nurses traditionally had.

The silencing of death has been an on-going issue. Armstrong (1987) suggests that death is driven into secrecy and this is the root of problem. If death was given more explicit attention and talked about openly, perhaps the fears and anxieties would be lightened and this would ultimately improve the quality of patient and family centered care. Although careful consideration has been given to the death- defying culture, this problem still continues to exist.

6.1.2 Psychosocial care

The notion of psychosocial care was first seen in the 1970s and is a recurrent theme across each of the decades in this study. Psychosocial care was examined through the care of patients, families, and health care professionals. Psychological growth was a key area for student learning to identify and appreciate the dying process, family needs, management of physical distress, and the cultural aspects of care (Bloch, 1976). Learning the steps to care for a dead body are fundamental for nursing and medical curricula to include in their training. Learning how to communicate information to families and providing them with support is a key role of health care providers. The psychological education focused on how to be present with families during times of denial, grief, and loss and acknowledging the fears and emotions associated with death (Stefan & College, 1978). Barton et al. (1972) focused on the psychosocial processes and sociocultural issues surrounding death so that students were aware of the social factors and personal feelings and fears patients had about dying. Students had the opportunity to engage in activities such as writing their own obituary to bring into perspective the concepts of denial, fear, and grief (Stefan & College, 1978). Psychological processes associated with dying were examined through didactic lectures and experiential learning through patient contact in the clinical setting. This idea was further examined in the 1980s where Degner and Gow (1988a) suggested that learning about psychosocial care and the physical changes that occurred when

people near death were vital components to death education to ease the anxiety that students may have in caring for this population. This argument reflects a renewed emphasis on the importance of addressing psychosocial needs by nurse educators in the late 1980s.

There was also a change in how psychosocial care was examined in the literature in the 1990s and the first decade of the 21st century. Psychosocial aspects of care were focused on in terms of family centered care as well as caring for the well-being of members of the interdisciplinary team. In this context, there was a new attention to grief and loss in relation to the dying process (Hurtig & Stewin, 1990; Kirchhoff et al., 2003; Knight & Eifenbien, 1993; Mermann et al., 1991; Paice et al., 2006; Potter & Perry, 1997; Thompson, 2005;; Wallace et al., 2009). The widely disseminated work of Kubler-Ross has been central to Canadian nursing curricula. Specifically, the Potter and Perry (2006) nursing textbook examined in this study had an entire chapter dedicated to concepts and theories related to grieving and loss. Aiding families and loved ones with the grieving process was seen as central to providing holistic care to those affected by the death.

In addition to the grieving experience of patients and families, there was new emphasis on the experience of students who had previous experience with the death of a loved one (Knight & Eifenbien, 1993). Hurtig and Stewin (1990) suggested that students with previous experiences with death might appreciate didactic learning approaches as opposed to experiential learning approaches about the dying process as it is less intensive. The emotions and anxieties that students may have about death and dying could be made worse if they are not handled appropriately.

6.1.3 Educators

One goal of this study was to explore how educators might be supported to teach material on death and dying. This topic, however, still remains silent in scholarly journals and textbooks, which seems a striking finding. No explicit attention is given on how to best support educators, even though many articles suggest there is a lack of confidence and interest amongst faculty to teach death related topics (Dickinson & Mermann, 1996; Mallory, 2003; Perez et al., 1980; Wass, 2010). The literature identifies that students may benefit from having faculty from other disciplines speak to their class about the roles and responsibilities they have in caring for dying patients (Perez et al., 1980). The team-oriented approach for teaching the death course may also provide support for instructors who are not solely responsible for teaching an entire course but can rely on other faculty and learn from the teaching styles and experiences of their colleagues (Dickinson & Mermann, 1996). Team-teaching can provide support to educators and also invite new perspectives for student learning. As such, team-teaching seems to be an indirect way to support teachers in teaching about death and dying.

Integration of death concepts in an existing curriculum is one method to increase faculty interest in teaching these topics. Integration of death related topics within existing courses seems to make teaching this material easier for faculty as they do not need to create new learning tools but instead can incorporate the information within their existing lectures (Barnard et al., 1999; Degner & Gow, 1988a; Dickinson & Mermann, 1996; Wallace et al., 2008). For example, students can learn about the physiology of pain management for dying patients including dosing, interactions, and routes of administration within their pharmacology course (Barnard et al., 1999). Similarly, when medical students take part in dissecting the human cadaver in anatomy class, instructors could integrate discussions about fears, anxieties, and emotions associated with

dying patients (Barton, 1972; Dickinson & Mermann, 1996). These ideas suggest that death education does not have to be taught as an independent course, which may be less overwhelming for educators.

6.2 Recommendations

In addition to the need to address the three identified themes above, some further specific recommendations can be drawn from this review with regard to pedagogical approaches. There are several key teaching methods presented and recommended in this review that seem to be supported consistently as best practice. These recommended teaching methods and approaches are as follows:

- 1) patient as teacher
- 2) simulation based learning
- 3) collaborative care and team training
- 4) death and dying competencies to ensure consistency

6.2.1 Patient as teacher

A patient who is dying has the potential to offer students insights into their experience with the dying process. Experiential learning with direct patient contact is highlighted through the decades as the most ideal way for students to integrate their theoretical knowledge into practice (Birkholz et al., 2004; Bloch, 1976; Degner & Gow, 1988a; Dickinson, 2007; Downe-Wamboldt & Tamlyn, 1997; Johnson et al., 2009; Kavanaugh et al., 2009; Knight & Elfenbien, 1993; Listen, 1973; Mermann et al., 1991; Perez et al., 1980; Smith et al., 1980; Snyder et al., 1973; Ufema, 1977). The humanizing experiences illuminated through patient exposure cannot be replicated in textbooks or reading material. Therefore, exposure to dying patients during the early years of training will lead to more positive attitudes towards death and as a result, a more

positive approach to caring for people at the end of their life (Degner & Gow, 1988a; Mermann et al., 1991). Experiential learning also enables students to become socialized to the health care environment, gain understanding of the realities of the dying process and understand how their roles and responsibilities affect patient and family centered care.

6.2.2 Simulation based learning

Simulation based learning is recommended as an alternative method for students to practice their skills and apply their knowledge, when patient contact is not possible. Simulated experiences were introduced in the 1970s as a unique way to portray real life scenarios with patient, health care provider and family roles so that students would engage in conversation and discussion on how to manage difficult situations at the end-of-life (Stefan & College, 1978). Whereas more recently it is seen as a solution to the limited number of clinical learning experiences. Simulation offers a safe environment where students can practice their skills and patient care is not compromised (Bernard et al., 1999; Hurting & Stewin, 1990; Leighton & Dubas, 2009, Moreland et al. 2012; Stefan & College, 1978). As simulation technology has advanced, now high-fidelity simulation mannequins have the ability to use sound so voices can be mimicked to portray the changes of a dying patient making these scenarios realistic. Simulation encourages students to apply their critical thinking and problem solving skills in a less stressful environment where they are surrounded by the support of their instructors and colleagues leading to increased self confidence and self efficacy to be able to care for dying patients on their own (Moreland et al., 2012). On a personal level, simulation has increased my confidence to manage critical situations, as I was able to practice my skills and dialogue in a safe, harm free environment where I knew I would receive feedback promptly from my instructor and colleagues. Simulation scenarios made applying these skills in the clinical setting

less stressful as I had gained confidence. It appears that the findings from this review confirm that observation. Simulation can be usefully applied in death education as well.

6.2.3 Collaborative care and team training

There are many complexities involved with care at the time of death that requires a multidisciplinary approach to meet both patient and family centered needs. Collaboration amongst the interdisciplinary team is recommended as the best method to meet these specific needs (Barton et al., 1972, Cavaye & Watts, 2010; Degner & Gow, 1988a). Furthermore, team training is essential for health care professionals to develop their teamwork skills, learn about the roles of other members of the health care team, develop mutual respect and form trusting relationships (Barton et al., 1972; Degner & Gow, 1988a; Fineberg et al., 2004). Team training also supports learning about death from multiple disciplinary angles, which offers new insights and perspectives about death and dying care (Fineberg et al., 2004; Thompson, 2005). Several curricula invited faculty members of other disciplines than their own to serve as guest speakers to enlighten students on their personal experiences and roles in caring for patients at the end-of-life (Dickinson & Mermann, 1996; Downe-Wamboldt & Tamlyn, 1997). This team-oriented approach for instructors also encouraged students to adapt different perspectives to patient care. The rapidly changing and demanding health care environment consists of complex patient care with various family needs. Therefore, interdisciplinary collaboration helps divide the roles and responsibilities to provide the best quality care to those dying.

6.2.4 Death and dying competencies to ensure consistency

In the 1990s and 21st century, there was a new influence of addressing learning needs through explicit competencies that had to be met and were described in a number of scholarly journals as guidelines for death and dying education. In the previous decades explored, there

were no specific learning objectives outlined for death education. Articulation of the American Association of Colleges of Nursing (AACN) and End of Life Nursing Education Consortium (ELNEC) competencies provided clear learning outcomes for students and educators on essential death and dying learning that would need to be taught to students in their curriculum (Birkholz et al., 2004; Johnson et al., 2009; Kirchhoff et al., 2003; Paice et al., 2006).

These competencies included content on pain and symptom management, culturally competent care, ethical and legal issues, communication, loss, grief, bereavement and care of the dead body (Paice et al., 2006; Thompson, 2005). These core concepts were taught using various teaching strategies including videotape, role play, group discussions and film clips (Thompson, 2005). The competencies promoted consistency amongst all nursing and medical curricula, which helped improve the quality of patient care by ensuring consistency of the knowledge gained within school. Core competencies also provide direction for educators who are teaching these topics and inform them of the necessary information and tools students need to practice safely. Competencies also could serve as a basis for providing support and direction to educators who might find teaching this culturally charge topic challenging.

6.3 Conclusion

Death education has been and continues to be a challenging area to teach and learn. The lens of performance theory helped to understand how death education has been enacted over time. The findings from this study support the viewpoint that cultural ambivalence about death needs to be faced in death education so that avoidance is not reproduced but rather dealt with by creating confidence and opportunity to communicate death and dying. The manner in which cultural norms shape communication was emphasized in several studies, suggesting that the relationship between culture and death education is an important area for further research.

Furthermore, the importance of psychosocial care and the systematic incorporation of relevant theoretical concepts such as grief and loss needs to be incorporated in death education through appropriate pedagogical strategies while physical care for the dead body should receive explicit attention. Finally, the lack of support for educators providing death education was a striking finding that needs more scholarly attention, both in research and education.

Birth and death are both natural experiences, but the amount of focus the birthing process was given in my nursing training compared to the dying process is astounding. During my training almost five years ago, we received specific clinical placements dedicated to maternity and pediatrics where we were in the position to have experiential learning opportunities. However, we were given no specific clinical experiences in a palliative ward. The only experiences I had with dying patients were in my encounters on rare occasions within my other clinical placements. From this integrative review, it appears my student learning experience was no exception. Providing a supportive and pedagogically sound learning environment on the human experience of death and dying and end-of-life nursing care has been a persistent challenge throughout the latter half of the 20th century and into the current time.

The literature review reveals a strong and persistent emphasis on the need for student preparation during their training in order for them to develop the confidence, competence and appropriate attitudes in addressing the complexities involved with death, dying, and grief. The recommendations for teaching methods and pedagogical strategies including patient exposure, open communication, simulation based learning, and collaborative care have value beyond “how to” in death education. They can be usefully integrated when teaching other nursing and medical topics and approaches. For example, simulation based learning and interdisciplinary teamwork are key factors to consider for critical life threatening situations such as a code blue. These

recommendations can also be applied to teaching patient and family centered care and have the potential to positively impact student learning.

The persistent themes and repetition of challenges reported in the literature across the decades including the avoidance of death at the culture at large, the psychosocial aspects of care, and the lack of support for educators all indicate either a gap in the current curricular designs or an area in need of development that needs to be addressed. The initiative for competency based death education has been an important first step towards curricular change and a more systematic incorporation of death education. Further attention must be given to placing death education on solid pedagogical footing so that there is continued attention to these vital topics within nursing and medical curricula. Furthermore, the need for psychosocial aspects of care for all stakeholders involved including patients, families, health care professionals and students was evident throughout the literature examined in this study. Hence, these concepts need careful consideration in death education courses.

While student learning and support is necessary for optimal patient care, educators also need guidance to teach these difficult topics that are viewed as taboo in society. Although the lack of confidence and preparedness amongst educators is expressed throughout this review, more exploration and research is needed into how educators can be best supported. Since death and dying education is receiving more attention and deemed as necessary for student learning before practice, providing support and training to educators should also be essential. Some suggestions offered in the literature review included a team-oriented approach to teaching death courses as well as the integration of death related topics within existing curricular courses. This area needs careful examination and more future research. In order for student learning to take

place, educators need to be confident in their roles as teachers; therefore, supporting both students and educators is equally important.

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